

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. In case of death, clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

07900

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County..... Allegany.....

City or town..... Cumberland, Md. ....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital.....

How long in hospital or institution?..... 3 days.....

## 3. (a) FULL NAME

Howard T. Athey

4. Sex ..... 5. Color or race ..... 6. (a) Single, married, widowed, or divorced

Male White widower

6. (b) Name of husband or wife..... Josephine Korn.....

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1879

8. AGE: Years 68 Months 10 Days 10 If less than one day hrs. min.

9. Birthplace..... Keyser, W. Va. ....  
(Town, county, and state)

10. Usual occupation..... retired shop foreman

11. Industry or business..... Railroad

12. Name..... Thomas Athey

13. Birthplace..... Moorefield, W. Va.

14. Maiden name..... Carrie Sytinger

15. Birthplace..... Romney, W. Va.

16. Informant..... Mrs. Myrtle Hensell

Address..... 911 Brentwood St.

17. Cremation? Date thereof..... August 19, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cedar Hill

Location..... Washington, D.C.

18. Funeral director..... John J. Neff

Address..... Cumberland, Md.

19. Aug. 18, 1948..... Walter A. Tracy, M.D.  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. .... County..... Allegany.....

City or town..... Cumberland.....  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 28 Taing Ave.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

219-03-9604

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 15 19 48, 11, 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug. 16 19 48.

Immediate cause of death.....

Hemothorax, due to a crushed chest, left side, 2nd, 3th, 4th, &amp; 5th ribs fractured.

Due to being hit by a passenger train engine at Baltimore St. crossing 8-12-18-9-30 P.M.

Due to

Other conditions..... Fracture of pelvis &amp;

abrasions, left side of face, hand &amp; knee. (Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results..... yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident.... Date of 8-12-48

Where did injury occur? Cumberland, Allegany, Md. ....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .... as above

Means of injury..... Hit by an engine Injured at work? no

Deputy Medical Examiner = Allegany Co.

23. SIGNATURE..... H. V. Denning, M.D. H. V. Denning, M.D.

M. D. or other

Address..... Cumberland, Md. .... Date signed 8-16-48

RECEIVED  
AUG 24 1948  
BUREAU ▶. S.

M  
Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

## 3. (a) FULL NAME

MR BERNARD BEYOLKEY

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6.(b) Name of husband or wife ANNA KRIEGER Kiffner

7. Birth date of deceased (mo., day, yr.) October 8, 1872 6.(c) If alive, give age 68 years

8. AGE: Years Months Days If less than one day  
75 10 8 . . . . . hrs. . . . . min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual occupation RETIRED (B &amp; O)

## 11. Industry or business

BEYOLKEY JACOB

13. Birthplace GERMANY

14. Maiden name KRIEGER ANNA Mary ?

15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE CITY

17. Burial Date thereof August 19, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Cumberland, Md.

18. Funeral director John J. Wilson

Address Cumberland, Md.

19. Aug 18 1948 Writer D. Williams  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 630 ELM ST CITY

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

705-12-2269

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 16

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

10-24 1948 to Aug. 16 1948  
and that I last saw him alive on Aug. 16 1948

Immediate cause of death

Refractory arterio  
sclerosis (marked)  
Diabetes  
arteriosclerosis.

Sect. 10.

Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE D. F. Williams

M. D.

Address Cumberland, Md. Date signed 8-17-48

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07902

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

~~Within corporate limits~~

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

In his automobile, Frederick St. near  
George St.

How long in hospital or institution?

## 3. (a) FULL NAME

Lawrence G. Bittinger

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Elizabeth Q. Bittinger

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

Nov. 1- 1886

8. AGE: Years Months Days If less than one day  
61 hrs. min.

9. Birthplace Grantsville Md.

(Town, county, and state)

10. Usual occupation Retired, rural mail carrier.

## 11. Industry or business

12. Name Thomas H. Bittinger

13. Birthplace Grantsville Md.

14. Maiden name Elizabeth Hoover

15. Birthplace Grantsville Md.

16. Informant Wife) Elizabeth Q. Bittinger

Address Grantsville Md.

17. Burial Date thereof Aug 29, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grantsville

Location Grantsville Old yards

18. Funeral director Mrs. Alister Lang

Address Grantsville Old

19. Date rec'd by registrar Aug 28, 1948 Under G. J. M. M. D. H. V. Deming M.D.

(Date rec'd by registrar) (Registrar) M. D. or other

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Garrett

City or town Grantsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1948 af 5 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive Dead Aug. 26 1948

Immediate cause of death

Chronic myocarditis

DURATION

2 yrs.

Due to

Due to

Other conditions Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

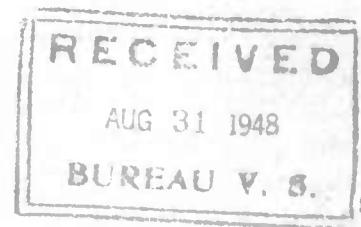
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming, M.D. H. V. Deming M.D.

M. D. or other

Address Aug. 26-1948 Date signed Aug. 26-1948





PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. In  
correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

07903

**MARYLAND STATE DEPARTMENT OF HEALTH**  
2411 N. Charles St., Baltimore 164C

**CERTIFICATE OF DEATH**

Reg. Dist. No. 10

**1. PLACE OF DEATH:**  
 County Allegany  
 City or town Slabtown, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
Highway, near home

How long in hospital or institution?

**3. (a) FULL NAME** Robert Leo Bridges

4. Sex <u>male</u>	5. Color or race <u>white</u>	B. (a) Single, married, widowed, or divorced <u>married</u>
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6. (b) Name of husband or wife Wauneta R. Lease Bridges

7. Birth date of deceased (mo., day, yr.) Oct. 27-1914

8. AGE: Years 35 Months 9 Days 21 If less than one day  
 hrs. ..... min. ....

9. Birthplace Elk Garden, W. Va.  
 (Town, county, and state)

10. Usual occupation Steel Worker

11. Industry or business Hazelwood Contracting Co.

**MOTHER FATHER**

12. Name Edgar L. Bridges

13. Birthplace Beans Cove, Pa.

14. Maiden name Grace Ream

15. Birthplace Bedford Co., Pa.

16. Informant Mrs. Leo Bridges  
 Address Slabtown, Md.

17. Burial Date thereof 8/21/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery  
 Location Mt. Savage, Md.

18. Funeral director Jacob Hafer  
 Address 23 East Main Street, Frostburg, Md.

19. 8 - 20 1948 Jennia M. Deemer  
 (Date rec'd by registrar) Registrar

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State Md. County Allegany  
 City or town Slabtown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2. (a) If veteran, name war World War 2

**3. (b) Social Security Number** 220-10-8533

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Aug. 18 19 48 12 40 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
 19. , to 19. ,  
 and that I last saw him dead Aug. 18 19 48

Immediate cause of death Intracranial hemorrhage  
 DURATION at once

Due to a self inflicted 25 caliber  
Belgium automatic pistol wound  
through skull.

Other conditions  
 (Include pregnancy within 3 months of death)

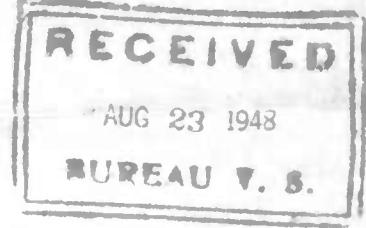
Major findings of operations  
 Date of op. \_\_\_\_\_

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Suicide Date of Aug. 18 48  
 Where did injury occur? Slabtown, Allegany, Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) near home  
 Means of Injury as above Injured at work? No

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
 M. D. or or or  
 Address Cumberland, Md. Date signed Aug. 18-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

67984

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

**M**  
**I**  
**O**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Allegany

City or town Slabtown Md.

(If outside city or town limits, write RURAL and give nearest town)

3 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Highway, near home

How long in hospital or institution?

## 3.(a) FULL NAME

Wauneta R. Lease Bridges

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Robert Leo Bridges

7. Birth date of deceased (mo. day, yr.) Aug. 31 - 1929

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
18 10 17 hrs. min.9. Birthplace Cresaptown, Md.  
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business Garment Factory

12. Name Vance Cecil Lease

13. Birthplace Cresaptown, Md.

14. Maiden name Mary E. Shuck

Cresaptown, Md.

15. Birthplace Cresaptown, Md.

16. Informant Mrs. Vance Lease

Address Cresaptown, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/21/48  
(month) (day) (year)

Methodist Cemetery

Cemetery or crematory

Location Mt. Savage, Md.

## 18. Funeral director Jacob Hafer

Address 23 East Main St., Frostburg, Md.

19. 8-20 1948 Verne M. Germer  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Slabtown  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

212-24-1444

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948 at 12.40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her Dead Aug. 18 1948

Immediate cause of death

Intracranial hemorrhage  
(Homicide)Due to being shot by her husband  
in head by a 25 caliber belgian  
automatic pistol.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 8-18-48

Where did injury occur? Slabtown Allegany Md.  
(City or town) (County) (State)

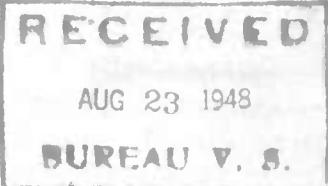
Injured at home, farm, industry, public place (where?) near home

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Denning M.D.  
M. D. or other

Address Cumberland Md. Date signed 8-18-48



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07905

93d

9

## CERTIFICATE OF DEATH

Reg. Dist. No....

## 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital institution, or street address where death occurred:

7 S. Bernard St.

How long in hospital or Institution? .....

## 3. (a) FULL NAME

Martha Lucinda Broderick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) January 1st 1870

6. (c) If alive, give age .....

years

8. AGE: Years 78 Months 7 Days 13 If less than one day .....

hrs.

min.

9. Birthplace Westonport Md.  
(Town, county, and state)10. Usual occupation House keeper.

## 11. Industry or business

12. Name Thomas Broderick13. Birthplace Ireland14. Maiden name Lavinia Carney15. Birthplace Mt. Savage Md.16. Informant Helena CollierAddress 7 S. Bernard St.17. Burial Burial Frostburg Md.  
(Burial, cremation, or removal. Which?) Date thereof Aug 14 1948  
(month) (day) (year)Cemetery or crematory St. Peter CemeteryLocation Westonport Md.18. Funeral director Jacob HaferAddress 238 Main St. Frostburg Md.19. 8-14 1948 20. Ms. Harvey A. Rue  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 S. Bernard St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948 at 12:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Aug. 13 1948  
and that I last saw her alive on Aug. 13 1948

Immediate cause of death.....

Chv. Myositis DURATION 1 year

Due to.....

Severe AlthritisSevere ArthritusDURATION 12 years

Dother conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

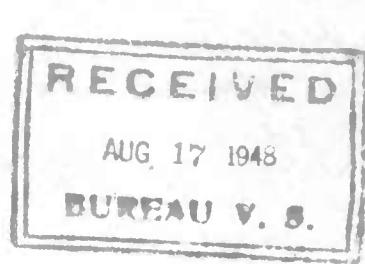
Means of injury

Injured at work?

23. SIGNATURE Wom Fane

M. D. or other

Address Frostburg Md. Date signed 8-14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct answers, check the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07906

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany

City or town Westerport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

326 Spruce St.

How long in hospital or institution? - - - - -

## 3. (a) FULL NAME

Edward Adolf Brumback

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

White

Married

Grace Wilson

## 6. (b) Name of husband or wife

Brumback.

6. (c) If alive, give age: 62 years

## 7. Birth date of deceased (mo., day, yr.)

February 25, 1890

## 8. AGE:

Years

Months

Days

If less than one day

58

5

19

hrs.

min.

## 9. Birthplace

Liberty Furnace, Virginia

(Town, county, and state)

## 10. Usual occupation

Machinist

## 11. Industry or business

W.Va. Pulp &amp; Paper Co.

Amos Brumback

## MOTHER FATHER

## 12. Name

Virginia

## 13. Birthplace

Rebecca Miller

## 14. Maiden name

West Virginia

## 15. Birthplace

Mrs. Grace W. Brumback

## 16. Informant

West Westerport, Maryland

## Address

Burial

Date thereof Aug 17, 1948

(month) (day) (year)

(Burial, cremation, or removal, which?)

## Cemetery or crematory

Philadelph Cemetery

## Location

Westerport, Maryland

## 18. Funeral director

Ellsworth S. Baal

## Address

Westerport, Maryland

## Date paid by registrar

Aug 17, 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

Maryland

## County

Allegany

## City or town

Westerport

## County

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

326 Spruce St.

## County

(If rural, give LOCATION)

## 2.(a) If veteran, name war

d. w. w. i.

## 3. (b) Social Security Number

216-05-0724

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

August 14 1948 at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1947 to Aug 14 1948

and that I last saw him alive on Aug 13, 1948

1948

## Immediate cause of death

## Due to

Coronary Occlusion

5 minutes

## Due to

Coronary Heart Disease

1½ years

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

## Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

## Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

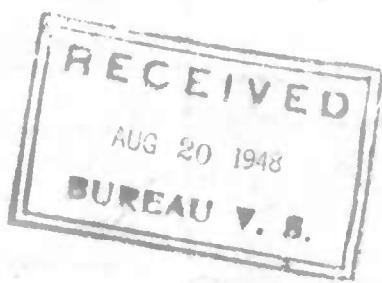
## 23. SIGNATURE

James E. Weston Jr. M.D.

M.D. or other

Piedmont &amp; W. Va. Date signed 8-15-48

## Address



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07907

63B

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

M  
Margin reserved for binding

1. PLACE OF DEATH:  
 County Allegany  
 City or town Frostburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred: Miners Hospital  
 How long in hospital or institution? 2 weeks & days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No 139 E College Ave.  
 (If rural, give LOCATION)

## 3. (a) FULL NAME

Margaret Elizabeth Buckalew

BUCKALEW

## 3. (b) Social Security Number

4. Sex Female Color or race 5. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife George P. Buckalew

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1895 6. (c) If alive, give age 51 years

8. AGE: Years Months Days If less than one day  
52 8 5 hrs. min.9. Birthplace Frostburg, Allegany Co., Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name John L. Beggs

13. Birthplace Scotland

14. Maiden name Sara E. Tracy

15. Birthplace Frostburg, Md.

16. Informant Mr. Geo. R. Buckalew

Address Frostburg, Md.

17. Burial Date thereof Aug. 31, 1948  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Mrs. Eichhorn

Address Lonas Avenue, Md.

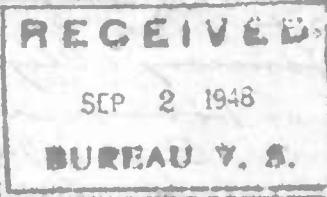
19. 8-31-48 Mrs. Lucy A. Fox  
(Date rec'd by registrar)

Registrar

(34444444)  
BUCKALEW

BUCKALEW

&lt;/div





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness  
is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOLSON

Evidence for addition of  
# 3b, & correction of 6c, 13 & 16  
shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07903  
4

DO. G 11 / AUG 25 1948 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

4 DAYS

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?.....

4 DAYS

## 3. (a) FULL NAME

JAMES W. BUTT

4. Sex

MALE

WHITE

MARRIED

6. (b) Name of husband or wife..... ADDA McCURDY BUTT

6. (c) If alive, give age..... 64 66 years

7. Birth date of deceased (mo., day, yr.)

AUGUST 6, 1877

8. AGE: Years	Months	Days	It less than one day
71	0	7	hrs. min.

9. Birthplace..... Shawnee, OHIO  
(Town, County, and state)

CLERK

10. Usual occupation.....

11. Industry or business..... STORE IN OAKLAND

12. Name..... SAMUEL BUTT

13. Birthplace..... WEST VIRGINIA Ohio

14. Maiden name..... RUTH KIMMY

15. Birthplace..... OHIO

16. Informant..... Adda McCurdy Butt

Address..... Oak St, Oakland Md.

17. Burial..... Aug 16, 1948  
(Burial, cremation, or removal. Which?)

Date thereof. Aug 16, 1948  
(month day year)

Cemetery or crematory..... Oakland Cemetery

Location..... Oakland Md.

18. Funeral director..... Herbert Leighton

Address..... Oakland Md.

19. Date rec'd by registrar..... Aug 14 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND

County.....

GARRETT

City or town..... OAKLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No..... OAK STREET

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

216-07-7069

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... AUGUST 13, 1948, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-9-1948, to 8-13-1948

and that I last saw him alive on 8-13-1948

Immediate cause of death.....

Arteriosclerosis with Coronary sclerosis

DURATION

Due to.....

Due to.....

Other conditions..... Benign hypertrophy prostate

Vesical calculus

(Include pregnancy within 8 months of death)

Major findings of operations..... no operation

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

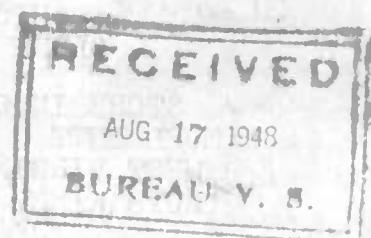
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Howard Tolson, M.D.

M. D. or other

Address..... Cumberland, Md. Date signed..... Aug 14 1948



Outside of  
limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07905

170C

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County

*Allegany*

City or town

*Cumberland Md*

(If outside city or town limits, write RURAL and give nearest town)

Rural RFD 28 miles S

How long in above place of death?

Memorial Hospital

Hospital, institution, or street address where death occurred:

*Memorial Hospital Cumberland Md*

How long in hospital or institution?

### 3. (a) FULL NAME

*Espen L. Cannon*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male*

*White*

*single*

### 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

*Nov. 29, 1928*

8. AGE:

Years

Months

Days

If less than one day

*19*

*8*

*15*

hrs.

min.

9. Birthplace

*Hampshire Co*

*W. Va*

(Town, county, and state)

10. Usual occupation

*Labor*

*Green Spring W. Va*

11. Industry or business

*Copper Co Tie Plant*

12. Name

*Cecil P. Cannon*

13. Birthplace

*W. Va*

14. Maiden name

*Naomi O. Bunner*

15. Birthplace

*Maryland*

Address

*Springfield W. Va*

16. Informant

*Albert Cannon (Brother)*

Address

*Springfield W. Va*

17. Burial

*Burial*

(Burial, cremation, or removal, Which?)

Date thereof

*Aug. 17, 1948*

(month)

(day)

(year)

*(month)*

*(day)*

*(year)*

*(month)*

*(day)*

*(year)*

Cemetery or crematory

*Forest Glen*

Location

*Green Spring W. Va*

18. Funeral director

*A. C. Rockman*

Address

*Romney W. Va*

19. Date rec'd by registrar

*Aug. 15, 1948*

(Date rec'd by registrar)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*W. Va*

County

*Hampshire Co*

City or town

*Greenspring W. Va*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

*234-40-3397*

*about*

### MEDICAL CERTIFICATION

20. DATE OF DEATH

*Aug 14 1948*

*1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. to 19.

and that I last saw him *dead Aug 15*

*1948*

Immediate cause of death

*Exsanguination -*

DURATION

*6.31*

Due to large lacerations of right thigh also left side of abdomen extending from

Due to anterior spine to mid sacral region

Excavation of ilium

Other conditions Fracture of femur bone

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Auto accident* Date of *Aug 14/48*

3rd party *T. C. Romay* Where did injury occur? *Hampshire Co W. Va*

(City or town) (County) (State)

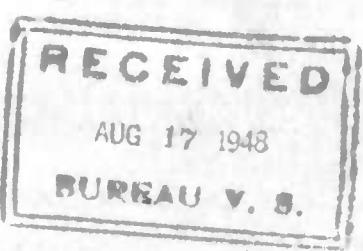
Injured at home, farm, industry, public place (where?) *Highway*

Means of injury *Auto struck patient* Injured at work? *No*

Deputy Medical Examiner - *Allegany Co*

23. SIGNATURE *H. V. Drury MD* M. D. or other

Address *Cumberland Md* Date signed *Aug 15/48*



PLEASE WRITE PLAINLY, WITH LEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 days

## 3. (a) FULL NAME

John T. Carney

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Helen Mc Elwee

6.(c) If alive, give age years

7. Birth date of deceased (mo. day yr.) August 11, 1885

8. AGE: Years 63 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Mt. Savage, Maryland  
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Steel mills

12. Name John Carney

13. Birthplace Mt. Savage, Md.

14. Maiden name Bridget Muloney

15. Birthplace Ireland

16. Informant Raymond W. Fannan

Address Mt. Savage, Md.

17. Burial Date thereof August 14, 1948  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Calvary Catholic Cemetery

Location Youngstown, Ohio

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Aug. 12, 1948 W.R. Fahey, M.D.  
(Date recd by registrar) Registrar

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07910

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Mahoning

City or town Youngstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2715 17th. Vernon Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 am, 1948, to 11 pm, 1948  
and that I last saw him alive on 11 am, 1948

Immediate cause of death

Cerebral hemorrhage 1 week

Due to Hypertension resulting  
deceased.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

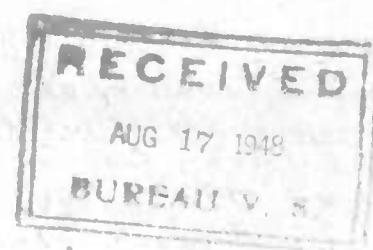
Means of injury

Injured at work?

23. SIGNATURE W. Alfred Von Oers

M. D. or other

Address Campbelton, Md. Date signed Aug. 12, 1948



**M** PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. It is especially important. Physicians: please write the causes of death clearly and legibly.

**Within corporate limits**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07911  
9102

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County... **Allegany**

City or town... **Cumberland Md.**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **50 - 8 - 27**

Hospital, institution, or street address where death occurred:

**551 N. Mechanic St.**

How long in hospital or institution? D.O.A. at Allegany Hospital **1 day**  
(If veteran, name war.)

### 3. (a) FULL NAME

**Reed Christopher Cassen**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife	Loretta A. Miller Cassen
-------------------------------	--------------------------

6.(c) If alive, give age **48** years

7. Birth date of deceased (mo., day, yr.) **Nov. 22- 1897**

8. AGE: Years	Months	Days	It less than one day
50	8	27	hrs. min.

9. Birthplace... **Cumberland Md.**  
(Town, county, and state)

10. Usual occupation... **City policeman**

### 11. Industry or business

12. Name	Jarriet W. Cassen
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13. Birthplace	Cumberland Md.
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14. Maiden name	Ellen Jane Hoenicka
-----------------	---------------------

15. Birthplace	Cumberland Md.
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16. Informant	Mrs. Elizabeth McIntosh (sister)
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Address	225 Bond St. Cumberland Md.
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17. Burial	Date thereof <b>Aug 21 '48</b> (Burial, cremation, or removal. Which?)
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Cemetery or crematory	Rose Hill Cem.
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Location	Cumberland
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18. Funeral director	Louis Stein Inc.
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Address	Cumberland
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19. Date recd by registrar	Aug 20 1948 H. V. Deming M.D. Registrar
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### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Md.** County... **Allegany**

City or town... **Cumberland**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. **551 N. Mechanic St.**  
(If rural, give LOCATION)

### 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 19 1948**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him **dead** Aug 19 1948

Immediate cause of death  
**Coronary occlusion**

DURATION  
**1/2 hr.**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?  
**Deputy Medical Examiner - Allegany Co.**

23. SIGNATURE **H. V. Deming, M.D.**  
M. D. or other

Date signed **8-19-48**

RECEIVED

AUG 24 1948

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07912  
6

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Westernport - Rural 2 Mi. Rt 135  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Genevieve M. Clark

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Jan 9, 1893

## 8. AGE:

55

Years

Months

Days

If less than one day

hrs.

min.

## 8. Birthplace.....

(Town, county, and state)

Clerk

## 10. Usual occupation.....

## 11. Industry or business.....

12. Name..... John B. Clark

13. Birthplace..... Wheeling, W.Va.

14. Maiden name..... Catherine Hussion

15. Birthplace..... Ireland

## 16. Informant..... Kathleen Howley

Address..... Wheeling, W.Va.

## 17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof..... Aug. 2 48

(month) (day) (year)

## Cemetery or crematory.....

Location..... Wheeling, W.Va.

## 18. Funeral director.....

Address..... Ellsworth S. Boal

Westernport, Md.

19. Date rec'd by registrar..... Aug. 2 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W.Va. County..... Ohio

City or town..... Wheeling

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 136-14th St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

Aug. 1

1948 8P.M.

## 20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug. 1  
Immediate cause of death..... Intracranial  
Hemorrhage due to fracture of skull.  
DURATION..... 3 Min.

Due to.....

Due to.....

Fracture of cervical Vertebrae  
& several ribs fractured on left side  
of chest, also right patellae fracture

Major findings of operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE of death was due to external causes. If in the following:

Auto Accident 8/1/48  
Accident, suicide, or homicide.....  
Where did injury occur? Near Westernport-Allegany-Md  
(City or town) Rt. 135  
(State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidentally thrown from auto

Deputy Medical Examiner - Allegany Co.

## 23. SIGNATURE..... H. V. Deming M.D.

M. D. or other

Address..... Cumberland, Md. Date signed..... 8/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07913

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County AlleganyCity or town Northbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

35 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

36 Mc Cullah St.

How long in hospital or institution?

## 3. (a) FULL NAME

Paul Costello4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorcedmarried6.(b) Name of husband or wife May Costello7. Birth date of deceased (mo., day, yr.) Feb. 2nd 18856.(c) If alive, give age 66 years8. AGE: Years 63 Months 6 Days 13 If less than one day

hrs. min.

9. Birthplace Italy (Sicily)

(Town, county, and state)

10. Usual occupation Petrol Cellanese worker.

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. May CostelloAddress 36 Mc Cullah St. Northbury17. Burial Burial Date thereof 8/15/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Allegany CemeteryLocation Northbury, Md.18. Funeral director Jacob J. TaperAddress 23 E. Main St. Northbury, Md.19. 8-18 19. 48 Mrs. Harvey S. Roe

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty AlleganyCity or town Northbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Mc Cullah St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

217-10-5190

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 15 1948at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to Aug 10 1948and that I last saw him alive on August 10 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

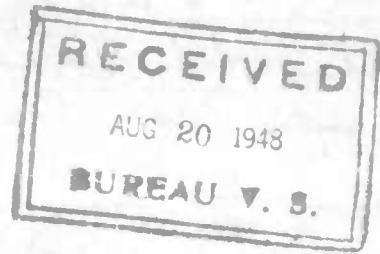
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. J. Gaffey M.D. M. D. or otherAddress Frontbury, Md. Date signed 8/18/48

(Date)



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07914

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 days

Hospital, institution, or street address where death occurred

Allegany Hospital

How long in hospital or institution?

10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Rural Cumberland

Street No.

Blk. # 5 Braddock Rd

(If rural, give LOCATION)

2.(a) Is veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1948 at 3:0 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21st 1948 to August 1st 1948 and that I last saw her alive on July 31st 1948.

Immediate cause of death cerebral hemorrhage DURATION 10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

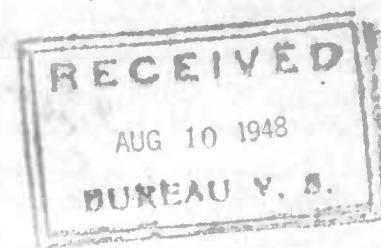
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 15 S. First St. Date signed 8-2-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

174

07915

8

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegany

City or town near Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waynesburg Mine #5

How long in hospital or institution? in mine 10 minutes

## 3. (a) FULL NAME

Robert Dodds

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife Heneritta Moffatt Dodds

7. Birth date of deceased (mo., day, yr.)

Feb. 17-1906

6.(c) If alive, give age 43 years

8. AGE: Years

Months

Days

If less than one day

42

5

27

hrs.

min.

9. Birthplace

Lonaconing Md.

(Town, county, and state)

10. Usual occupation mine foreman

11. Industry or business Georges Creek Coal Co.

MOTHER FATHER

12. Name John Dodds

13. Birthplace

Lonaconing Md.

14. Maiden name Myria Peudleberry

15. Birthplace Lonaconing Md.

16. Intormant

John Dodds Jr

Address

Lonaconing Md

17. Burial

Date thereof Aug. 17, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oak Hill Cemetery

Location

Lonaconing Md

18. Funeral director

Mr. Eichhorn

Address

Lonaconing Md

Aug. 17

1948

Jaunita M. Book

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Detmold, near Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

216-05-2969

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14

19 48 9 30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18. to 19.

and that I last saw h. im alive Dead Aug 14  
Immediate cause of death Asphyxiation and degree

1st, 2nd, &amp; 3rd burns all over body &amp; shock.

DURATION at once

Due to

Coal due to mine explosion from coal

dust methane gas ignited from

Other conditions an open type mine motor [9/14/48 also]

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-14-48

near Where did injury occur? Lonaconing Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in coal mine

Means of injury Coal dust explosion at work? yes.

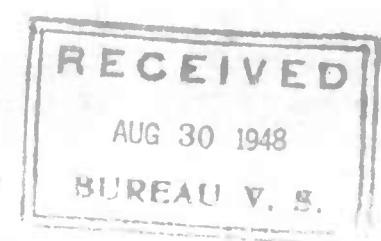
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M.D. or other

Address Cumberland Md.

Date signed 8-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size is especially important. Physicians: please write the causes of death clearly and legibly.

# Outside of City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07316

93d

### CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLACE OF DEATH: Allegany  
 County: R. D. #2 Cumberland, Md.  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 R. D. #2 Cumberland, Md.  
 How long in hospital or institution?

3. (a) FULL NAME

Hazel Liller Dowling

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife.....

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo. day, yr.) Mar. 27, 1890

8. AGE: Years	Months	Days	If less than one day
58	5	0	hrs. min.

9. Birthplace W. Va.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name	George Liller
13. Birthplace	W. Va.

14. Maiden name	Sarah Bobo
15. Birthplace	W. Va.

16. Informant Matthew Dowling  
 Address R. D. #2 Cumberland, Md.

17. Burial Date thereof Aug. 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Philos Cem.

Location Westernport, Maryland

18. Funeral director H. Wayne George  
 Address Cumberland, Md.

19. Aug. 30, 1948 United Methodist  
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State	Maryland	County	Allegany
City or town	R. D. #2 Cumberland, Md.	(If outside city or town limits, write RURAL and give nearest town)	
Street No.	Williams Road	(If rural, give LOCATION)	

2.(a) If veteran, name war

3. (b) Social Security Number

None

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1948 at 12:29 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 16, 1948 to Aug. 27, 1948  
 and that I last saw her alive on Aug. 26, 1948

Immediate cause of death Chronic Myocarditis DURATION 6 mo

Due to Coronary Thrombosis DURATION 6 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

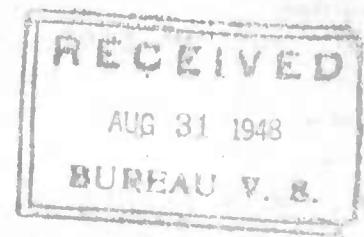
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE cleo. J. Surrell M. or other

Address Cumberland, Md. Date signed Aug. 28, 1948



DR. JACOBSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07917

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 10 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND County ALLEGANY

City or town

WESTERNPORT

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

GEORGE DUCKWORTH

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWER

6.(b) Name of husband or wife JANET METZ

7. Birth date of deceased (mo., day, yr.) MARCH 3, 1884

6.(c) If alive, give age years

8. AGE: Year 64 Month 5 Day 27 If less than one day hrs. min.

9. Birthplace WEST VIRGINIA

(Town, county, and state)

10. Usual occupation ODD JOBS

11. Industry or business

12. Name OLIVER DUCKWORTH

13. Birthplace MARYLAND

14. Maiden name SCHMIDT, FLORENCE

15. Birthplace WEST VIRGINIA

18. Informant Mrs Hospital Records

Address

17. Burial Date thereof Aug 29, 1948  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Westernport Cemetery

Location Westernport, Md.

18. Funeral director Ellsworth &amp; Sons

Address Westernport, Md.

19. Aug 29, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 27, 1948, at 1:26 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27, 1948, to Aug 27, 1948,

and that I last saw him alive on Aug 27, 1948.

Immediate cause of death

Carcinoma of liver

-&gt; (metastatic)

Due to

Other conditions

cancerous lung

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DR. JACOBSON

M. D. or other

Address 20 Westernport, Md. Date signed 8/29/48

RECEIVED

Aug 31 1948

FBI - BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 4

07918

## CERTIFICATE OF DEATH

98

## 1. PLACE OF DEATH:

County

Allegany  
Near Cumberland Rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Locust Grove, R. F. D. # 6

How long in hospital or institution?

## 3. (a) FULL NAME

Nettie Dunn

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Feb. 29 1880

8. AGE:

Years	Months	Days	11 less than one day
68	5	10	hrs. min.

9. Birthplace

(Town, county, and state)

MVA

10. Usual occupation

None

11. Industry or business

MOTHER FATHER	12. Name.....	George J. Dunn
	13. Birthplace	MVA

13. Birthplace

MOTHER FATHER	14. Maiden name.....	Elvina Alderton
	15. Birthplace	MVA

15. Birthplace

MOTHER FATHER	16. Informant.....	Miss Phoebe Baker
	Address	R. F. D. Locust Grove Md

16. Informant

MOTHER FATHER	17. Date thereof.....	Aug. 14 1948
	(Burial, cremation, or removal? Which?)	(month) (day) (year)

17. Date thereof

MOTHER FATHER	Cemetery or crematory.....	Rose Hill Cemetery
	Location.....	Cumberland Md

Cemetery or crematory

MOTHER FATHER	18. Funeral director.....	Louis Stein Inc
	Address	Cumberland Md.

Funeral director

MOTHER FATHER	19. Date rec'd by registrar.....	Aug. 10 1948 Ad. Frank M.D.
	Registrar	

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Alleg.

City or town

Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Locust Grove

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1948 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1948 to Aug 9 1948 and that I last saw her alive on Aug 8 1948

Immediate cause of death

General Staffylococcus infection of Expander

Due to: Dermatitis around with Bullous Gangrenous Granulation

Due to: malnutrition

DURATION

6 weeks

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

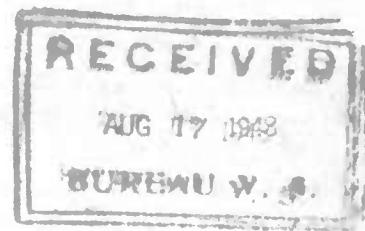
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE F. Alan H. Murray M.D. M. D. or other

Address: Cumberland Md. Date signed: Aug. 9 1948

Dunn



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07919

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 Years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? Six Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 318 Independence St

(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3.(a) FULL NAME

Joseph P. Faith

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife Annie Faith

7. Birth date of deceased (mo., day, yr.) July 14 1859  
.....(c) If alive, give age ..... years8. AGE: Years Months Days If less than one day  
89 1 15 ..... hrs. ..... min.9. Birthplace Hancock, Washington Co., Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Laborer

12. Name John Faith

13. Birthplace Germany

14. Maiden name Mary (Unknown)

15. Birthplace Unknown

16. Informant Mrs. Ira King

Address 318 Independence St, Cumberland, Md.

17. Burial Date thereof 8/25/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter Cemetery

Location Hancock, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Aug 23 1948 United Day M  
(Date rec'd by registrar) *L. King M.D.*  
Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 22 - 48 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 - 18 1948 to 8-22-1948

and that I last saw her alive on 8-22-1948

Immediate cause of death

Meningitis

DURATION

3 weeks

Due to: convulsions

fever

Due to: arteriosclerosis

6 mo

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*L. King M.D.*

M. D. or other

Address 58 Second St. Date signed 8-23-48

RECEIVED  
AUG 31 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07920

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH:  
 County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, Institution, or street address where death occurred:  
 210 Grand Ave, Cumberland, Md.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... W.Va. County..... Mineral  
 City or town..... Keyser  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 611 W. Piedmont St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME  
 Bertie Augusta Beall Gray

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... Winfield Scott Gray  
 3-16-47

7. Birth date of deceased (mo., day, yr.) Mar. 25 1884

8. AGE: Years Months Days If less than one day  
 64 4 27 hrs. min.

9. Birthplace..... Mineral Co. W.Va.  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

MOTHER FATHER  
 12. Name..... Joseph Beall  
 13. Birthplace..... W.Va.

14. Maiden name..... Joann Hartley  
 15. Birthplace..... W.Va.

16. Informant..... Joseph Gray  
 Address R#3, Keyser, W.Va.

17. Burial..... Date thereof..... 8-25-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Queenspoint  
 Location..... Keyser, W. Va.

18. Funeral director..... Rogers Funeral Home  
 Address..... Keyser, W.Va.

19. Date rec'd by registrar..... Aug. 25-1948  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1948 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1948 to Aug. 22, 1948 and that I last saw her alive on Aug. 22, 1948.

Immediate cause of death.....  
 Carcinoma of stomach  
 c carcinomatosis DURATION  
 172.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Aug. 25, 1948  
 Wm. A. Tandy, M.D. or other  
 Cumberland, Md. Date signed Aug. 27, 1948

Address.....

RECEIVED

AUG 31 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

07921

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

allegany  
cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1008 Gay st.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Catherine C. Foreman

7. Birth date of deceased (mo. day. yr.)

Sept. 5, 1857

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

90 10 28

hrs.

min.

9. Birthplace

Frederick, Md.

(Town, county, and state)

10. Usual occupation

Boatman - Retired

11. Industry or business

C & O Canal.

MOTHER FATHER

12. Name

Unknown

13. Birthplace

..

14. Maiden name

Unknown

15. Birthplace

..

16. Informant

John H. Gray

Cumberland, Md.

Address

Burial

Date thereof

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

LOUIS STEIN, INC.

Funeral director

Cumberland, Md.

Address

Aug. 4, 1948

(Date rec'd by registrar)

W.L. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Gay st.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1947 to Aug. 3, 1948

and that I last saw him alive on July 25, 1948

Immediate cause of death

Epistoleoma left neck

Due to

Due to

Other conditions metastasis cervical

& mediastinal glands

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

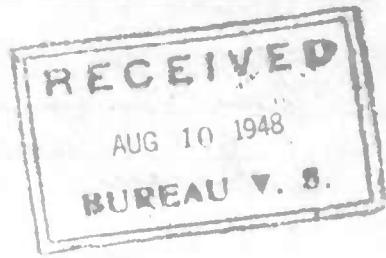
Means of injury

Injured at work

23. SIGNATURE R. E. Tracy, M.D.

M. D. or other

Address 122 So Centre Date signed 8-3-48



M  
I  
C  
Outside of  
City Limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07922

95c

## CERTIFICATE OF DEATH

Reg. Dist. No. *L*

## 1. PLACE OF DEATH:

County *Rural Route 2, Cumberland, Md.*  
 City or town *(If outside city or town limits, write RURAL and give nearest town)*

How long in above place of death? *2 yrs.*

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?

## 3. (a) FULL NAME

*Mrs. Willie Griffith*

4. Sex

5. Color or race

6. (c) Single, married, widowed, or divorced

*Female White widow*

6. (b) Name of husband or wife

*Thomas Griffith*

7. Birth date of

deceased (mo. day. yr.)

*June 6-1892*

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

Less than one day

66

2

15

hrs.

min.

9. Birthplace

*Frostburg Allegany Md*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

*George Hartig*

12. Name

*Germany*

13. Birthplace

*Mary 3 since*

14. Maiden name

*Frostburg Md*

15. Birthplace

*Carl Griffith*

16. Informant

*Route 2, Cumberland Md*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Aug. 24 1948*

(Month) (day) (year)

Cemetery or crematory

*Allegany Cemetery*

Location

*Frostburg Md*

18. Funeral director

*J. R. Durst*

Address

*Frostburg Md.*

19. Date rec'd by registrar

*August 24, 1948 W.R. Hartig M.D.*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Allegany*City or town *(Rural) Rd 2, Cumberland Md.*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 21 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw her *ER. Dead Aug. 22* 1948

Immediate cause of death

*Coronary occlusion*

DURATION

*at once*Due to *Coronary sclerosis*

Due to

Other conditions *Cardiac hypertrophy**Senile yrs*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

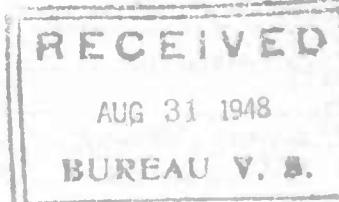
Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE *H. V. Dunning M.D.*

M. D. or other

Address *Cumberland Md.* Date signed *8-22-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

Dr. McLane  
07923

9

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

60 days

Hospital, Institution, or street address where death occurred:

miners Hospital

How long in hospital or institution?.....

24 hours

## 3. (a) FULL NAME

Thomas Henry Grose

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Mildred Grose

7. Birth date of deceased (mo., day, yr.)

July 2, 1900

6. (c) If alive, give age..... years

8. AGE:

Years  
48Months  
1Days  
13

It less than one day

hr.  
min.

9. Birthplace

Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation

electrician

11. Industry or business

Otis Elevator Co.

MOTHER FATHER

12. Name

James H. Grose

13. Birthplace

Maryland

14. Maiden name

Ollie Hager

15. Birthplace

Maryland

16. Informant

Edgar Grose

Address

Frostburg, Md.

17. Burial

Date there Aug 18, 1948

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Burst

Address

Frostburg, Md.

19. 8-18

1948 Mrs. Nancy K. Rus

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Los Angeles

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5911 S. Wilton Pl

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

320-10-7977

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 16 1948 at 12:25A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 12 1948 to Aug 16 1948

and that I last saw him alive on Aug 15 1948

Immediate cause of death

Cerebral Embolism

DURATION

25 hrs

Due to

Coronary Heart Disease

8 mo

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

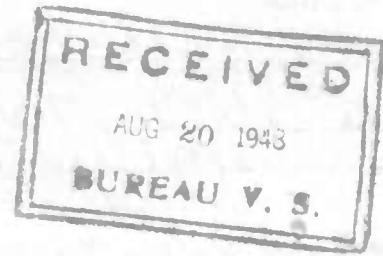
Injured at work?

23. SIGNATURE

M. D. or other

Address

Frostburg, Md. Date signed 8-16-48



I

2

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible entries will not be accepted.

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07924

95C

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? at once 2 hrs.

Hospital, institution, or street address where death occurred:

Front 38 Baltimore St.

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Edward Hartis Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Clemma Greenhorn Hartis

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo. day yr.) May 22 1885

8. AGE: Years Months Days If less than one day  
63 2 25 hrs. min.9. Birthplace Wilmington Del.  
(Town, county, and state)

10. Usual occupation Supervisor at Lukes Paper Mill

## 11. Industry or business

12. Name George Hartis

13. Birthplace Del.

14. Maiden name Elizabeth Cochran

15. Birthplace Del.

16. Informant Chas. E. Hartis Jr.

Address Luke Md.

17. Burial Date thereof Aug. 19 '48  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Philos Cem.

Location Westernport Md.

18. Funeral director Boal Funeral Home

Address Westernport Md.

19. Aug. 17 1948 United Mortg. Co.  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Pratt St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

216-09-6431

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17

19 48 at 12.10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive Dead Aug. 17

19 48

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to coronary sclerosis

about

3 yrs.

Due to

Other conditions Cardiac hypertrophy

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

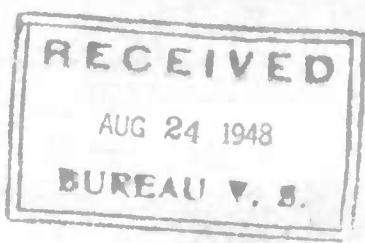
Injured at home, farm, industry, public place (where?)

Manner of injury Deputy Medical Examiner - Allegany Co. Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 8-17-48



1. Supply every item of information carefully. In case of death clearly and legibly.  
2. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07925  
9

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred.

38 Linden St (home)

How long in hospital or institution?

## 3. (a) FULL NAME

Marshall East Hill

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife

Lena Ella Lehr Hill

7. Birth date of deceased (mo., day, yr.)

March 18 - 1895

6. (c) If alive, give age 49 years

8. AGE:

Years Months Days If less than one day

53 4 27 hrs. min.

9. Birthplace

Borden Mines Md

(Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

Clayton Coal Co.

FATHER

12. Name

Robert W. Hill

13. Birthplace

Borden Mines Md

MOTHER

14. Maiden name

Annie Elizabeth Eister

15. Birthplace

Borden Mines Md

16. Informant

(wife) Mrs. Marshall Hill

Address

Frostburg Md

17. Burial

Date thereof 8/18/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

allegany Cemetery

Location

Frostburg Md

18. Funeral director

Jacob Hafer

Address

238 Main St. Frostburg Md

19. Date rec'd by registrar

8-18-48

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 Linden St

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

## 3. (b) Social Security Number

214-07-2523

## MEDICAL CERTIFICATION

20. DATE OF DEATH

8/15/45

19. to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

and that I last saw him Dead Aug 15 1945

at home

Immediate cause of death

Angina Pectoris

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

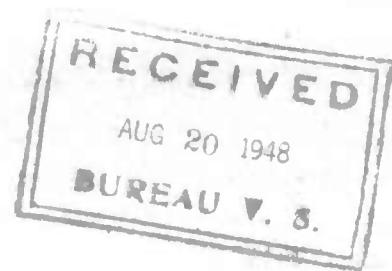
Deputy Medical Examiner Allegany Co

23. SIGNATURE

H. V. Dunning M.D.

M. D. or other

Address Cumberland Md Date signed 8-15-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07926

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**M** PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

One Day

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

One Day

## 3. (a) FULL NAME

Carrie Belle Hough

## 4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

Married

## 6. (b) Name of husband or wife

Raymond Hough

6. (c) If alive, give age 68 years

## 7. Birth date of deceased (mo., day, yr.)

March 17, 1878

## 8. AGE:

Years

Months

Days

If less than one day

70

5

2

hrs.

min.

## 9. Birthplace

Rainsburg, Pa.

(Town, county, and state)

## 10. Usual occupation

House Wife

## 11. Industry or business

12. Name William Morehead

MOTHER FATHER

Pa.

13. Birthplace

Susan Hoover

14. Maiden name

Pa.

15. Birthplace

16. Informant

Raymond Hough

Address

35 Pennsylvania Ave

17. Burial

Date thereof August 22, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Hillcrest

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. Aug 20 1948

Walter R. Gatz, M.D.  
Registrar

(Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 35 Pennsylvania Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from

August 18, 1948 to Aug. 19, 1948

and that I last saw him alive on Aug. 18, 1948

Immediate cause of death

Cystitis, Aspergillosis, Renal Disease

Due to

Diabetes Mellitus

Due to

Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. J. Williams  
Cumberland, Aug 20, 1948  
Address

M. D.

Date signed

RECEIVED  
AUG 24 1948  
BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct size  
is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of  
Within corporate limits  
**City Limits**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

07927

234

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegany

City or town Rocky Ford Camp, Town Creek Md.

(If outside city or town limits, write RURAL and give nearest town)

Rural about 1 year.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Henry Harrison Keith

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife Virginia B. Haines Keith

7. Birth date of deceased (mo., day, yr.) Dec. 15- 1881 6. (c) If alive, give age 28 years

8. AGE: Years Months Days If less than one day 66 7 29 hrs. min.

9. Birthplace Washington, Ind. (Town, county, and state)

10. Usual occupation Ry. Electrician

11. Industry or business Retired

12. Name Joseph Keith

13. Birthplace Ind.

14. Maiden name Mary Carroll

15. Birthplace Ind.

16. Informant Mrs. Donald Long

Address Ga Vale, Ind.

17. Burial Date thereof Dec. 16 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jim Deming, Cem.

Location Cumberland

18. Funeral director LOUIS STEIN, INC.

Address 117 Frederick St. Cysulld

19. Date rec'd by registrar Aug. 16, 1948 W. R. Grant, M.D.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rocky Ford Camp, Town Creek

(If outside city or town limits, write RURAL and give nearest town)

rural Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

705-09-9648

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1948 at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive Aug. 14 1948 to 1948

Immediate cause of death Intracranial hemorrhage &amp; exsanguination

Due to

Due to self inflicted revolver wound underneath chin, outlet of vertex of skull

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 8-14-48

Where did injury occur? Town Creek, Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Automatic pistol Injured at work? no

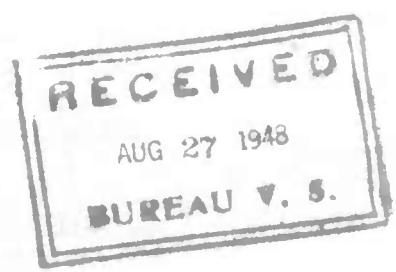
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming, M.D.

M. D. or

Date signed 8-14-48

Address Cumberland, Md.



Within corporate limits

Deming

M

H

C

B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07928

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Tilghman St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Anne Phillipa Kenny

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

November 9, 1906

8. AGE: Years Months Days If less than one day

41 9 2 hrs. min.

9. Birthplace Cumberland, Maryland  
(Town, county, and state)

10. Usual occupation Office Secretary

11. Industry or business Electric Contracting Co.

12. Name Thomas P. Kenny

13. Birthplace Midland, Md.

14. Maiden name Anna Blake

15. Birthplace Eckhart, Md.

16. Informant Mrs. Simon Kenny

Address Hagerstown, Md.

17. Burial Date thereof August 14, 1948  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

Cemetery or crematory St. Peter &amp; Paul's Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Hodges

Address Cumberland, Md.

19. Date recd by registrar Aug. 12 1948

Signature L.H. Frantz M.D.

Registrar

3. (b) Social Security Number

214-05-8993

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948, at 125 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1948, to Aug 11, 1948  
and that I last saw her alive on Aug 10, 1948

Immediate cause of death

Uremia

DURATION

2 days

Due to Interstitial nephritis

Due to

Other conditions Anemia & convulsions &  
hypertension  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H.V. Dunning M.D.

M. D. or other

Address Cumberland, Md. Date signed Aug. 12-48

RECEIVED  
AUG 17 1948  
BUREAU F. S.

0792

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175a

Within corporate limits

Reg. Dist. No.

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County Allegany  
City or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3. 1/2 days  
Hospital, institution, or street address where death occurred: Memorial Hospital  
How long in hospital or institution? about 3. 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State W.Va. County Hampshire  
City or town Springfield  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. rural - near Springfield W.Va.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

3. (a) FULL NAME

Eston Kesner

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced		
male	white	married		
6.(b) Name of husband or wife. Elliot P. Kessill Kesner				
6. (c) If alive, give age 51 years				
7. Birth date of deceased (mo., day, yr.) May 5 - 1882				
8. AGE:	Years	Months	Days	If less than one day
	66	3	18	hrs. min.
9. Birthplace Springfield W.Va. (Town, county, and state)				
10. Usual occupation Farmer				
11. Industry or business				
12. Name George Kesner				
13. Birthplace W.Va.				
14. Maiden name Rebecca Mozer				
15. Birthplace W.Va.				
16. Informant Glenn Kesner (son)				
Address Springfield W.Va.				

17. Burial Date thereof Aug 25 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Fessel Cemetery  
Location Moorefield W.Va.  
18. Funeral director Louis Sterio, Inc.  
Address Cumberland Md.  
19. Aug 24 1948 Hunter & Long, Inc.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948 at 9.55 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.  
and that I last saw him Dead Aug. 23 1948.  
Immediate cause of death Cerebral hemorrhage  
Due to basal fracture of the skull  
Due to Belt slipped off of hammermill, he caught belt which threw him against bottom wheel  
Other conditions Comminuted fracture of left forearm & hemerous, laceration of scalp, ear left side.  
Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide accident Date of 8-19-48  
Where did injury occur near Springfield, Hampshire, W.Va.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Farm  
Means of injury as above Injured at work? Yes  
Deputy Medical Examiner Allegany Co  
23. SIGNATURE H.A. V. Deming M.D. H.V. Deming M.D.  
M. D. or Dr.  
Address Cumberland Md. Date signed 8-23-48

RECEIVED  
AUG 31 1948  
BUREAU V. S.

DR. ELIASON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07930

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

## 3. (a) FULL NAME

MR. DAVID LAMB

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

MARIE HUMPHREY

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo. day. yr.)

APRIL 25, 1868

8. AGE:

80

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

MARYLAND  
(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

12. Name JOHN LAMB

13. Birthplace SCOTLAND

14. Maiden name JANE TAYLOR

15. Birthplace SCOTLAND

18. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVENUE

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 29 1948  
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Northwest Md

18. Funeral director

M. L. Lillard

Address

Lonaconing Md

19. Aug 27 1948

Wm. L. Lamb, M.D.  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

ALLEGANY

City or town LONA CONING

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

AUGUST 26, 1948

at 1:50A

20. DATE OF DEATH

Aug 26 1948 to Aug 26 1948

and that I last saw him alive on Aug 26 1948

Immediate cause of death

Colonic diverticulitis

Chronic diverticulitis

Due to: Stomach perforation

Due to: Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work?

23. SIGNATURE

H. L. Lillard, M.D.

M. D. or other

156 Main St. Cumberland, Md Date signed 8/26/48

RECEIVED  
AUG 31 1948  
BUREAU V. S.

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

07931

**MARYLAND STATE DEPARTMENT OF HEALTH**  
2411 N. Charles St., Baltimore 114 b  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 9

**1. PLACE OF DEATH:**  
 County: Allegany  
 City or town: Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 hours  
 Hospital, institution, or street address where death occurred: Union Hospital  
 How long in hospital or institution? 5 minutes

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State: Md. County: Allegany  
 City or town: Elkhardt  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

**3. (a) FULL NAME** Charles Andrew Lancaster Jr.  
**3. (b) Social Security Number**

4. Sex: Male	5. Color or race: White	6. (e) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Mary Chase		6. (c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): July 21 1876	6. (d) If less than one day: 77 yrs 2 mos 17 days hrs. min.	
8. AGE: Years: 77 Months: 2 Months Days: 17 Days	If less than one day: hrs. min.	
9. Birthplace: Elkhardt, Allegany Co.	(Town, county, and state)	
10. Usual occupation: Miner		
11. Industry or business: Coal		
12. Name: Robert Lancaster		
13. Birthplace: W. Va.		
14. Maiden name: Mary Chase		
15. Birthplace: W. Va.		
16. Informant: John Lancaster		
Address: 87 N. Frostburg, Md.		
17. (Burial, cremation, or removal. Which?) Burial	Date thereof: 8/1/48	(month) (day) (year)
Cemetery or crematory: Elkhardt Cemetery		
Location: Elkhardt, Md.		
18. Funeral director: Jacob Hager		
Address: Frostburg, Md.		
19. Date rec'd by registrar: 8-20 1948	Registrar: <i>Frank T. Harrel MD</i>	M. D. or other: <i>MD</i>
(Date rec'd by registrar)		Date signed: 8/19/48

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** August 18 1948 at 10:45 A.M.

**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1/8 1948 to 8/18 1948 and that I last saw him alive on 8/18/48**

**Immediate cause of death:**

① Bronchial asthma  
 Due to pneumonia & anthracosis  
 ② Cardiac failure, (R. sided)  
 Due to

**DURATION**

20 yrs ± 15 min

**Other conditions:**  
 (Include pregnancy within 3 months of death)

**Major findings or operations:**  
 Date of op.

**Autopsy results:**  
**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

**23. SIGNATURE:** *Frank T. Harrel MD*  
 M. D. or other: *MD*  
 Address: 59 E. Main St. Frostburg, Md.

RECEIVED

AUG 23 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH ONE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07932

93d

9

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

*Allegheny*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Life time

Hospital, institution, or street address where death occurred:

*R.W. #1, Eastbluff, Md.*

How long in hospital or institution? .....

## 3. (a) FULL NAME

*Mary Anne Lancaster*

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

*Chas. J. Lancaster*

7. Birth date of deceased (mo., day, yr.)

Aug. 14 - 1872

8. AGE:

Years

Months

Days

If less than one day

76

0

7

....hrs. ....min.

9. Birthplace

*Eckhart Allegany, Md.*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

*Mary Poppe*

12. Name

*Mary Poppe*

13. Birthplace

*Allegany*

14. Maiden name

*Unknown*

15. Birthplace

*Allegany*

16. Informant

*Mary Lancaster*

Address

*Eckhart Mtns, Md.*

17. Burial

*Burned*

(Burial, cremation, or removal, which)

Date thereof Aug. 22 - 1948  
(month) (day) (year)

Cemetery or crematory

*Eckhart Cemetery*

Location

*Eckhart, Md.*

18. Funeral director

*Jack Daffer*

Address

*Eastbluff, Md.*

19. Date rec'd by registrar

*8-22 1948*

19. Date rec'd by registrar

*Mrs. Harry V. Rae*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 21 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/20 1948 and that I last saw her alive on 8/20 1948

Immediate cause of death *Atrial fibrillation*, DURATION *Arteriosclerotic heart disease* 10 yrs

Due to

Brief death of husband 8/18/48

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

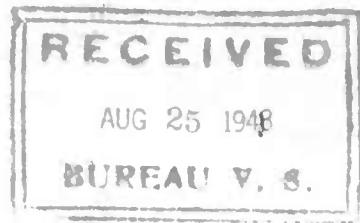
23. SIGNATURE

*Frank T. Harrington*

M. D. or other

Address

59 S. Main St., Post Office Box No. 1 Date signed 8/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# Outside of City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07936  
4

### CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

Allegany

City or town

Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, street address where death occurred:

Allegany Grove.

How long in hospital or institution?

## 3. (a) FULL NAME

Roy King Lease

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Jesse Dicken

7. Birth date of deceased (mo. day, yr.)

June 14 1902

6. (c) If alive, give age .. years

8. AGE:

Years

Months

Days

If less than one day

46

7

4

hrs.

min.

9. Birthplace

Creston Ind.

(town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

Issue Lease Ind.

13. Birthplace

Ind.

14. Maiden name

Sue Huff Ind.

15. Birthplace

Ind.

16. Informant

Roy L Lease

Address

Allegany Grove Ind.

17. Burial

Burial Aug 19 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lees Cemetery Ind.

Location

Creston Ind.

18. Funeral director

Loris Stein Inc.

Address

Cumberland

19. Date rec'd by registrar

Aug 20 1948 Wm D. Tracy M

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland

Street No. Allegany Grove

(If rural, give location)

2.(a) If veteran, name war

## 3. (b) Social Security Number

220-10-2330

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to Aug 18 1948 and that I last saw him alive on Aug 12 1948 1948

Immediate cause of death

Aggravated of heart

Due to: Other malnutrition 3 yrs and myocarditis 3 yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. Alan G. Murray M.D.

M.D. or other

Address Cumberland Md Date signed Aug 19 48

RECEIVED

AUG 24 1948

BUREAU F. B.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK,  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07934

47d

4

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

Allegany County

County.....

Cumberland, Maryland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

126 W. 3RD. Street

How long in hospital or institution?

## 3. (a) FULL NAME

Lisanti, Mr. Francis, Sr.

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Concetta (Frances) Lisanti

6. (c) If alive, give age 65 years

## 7. Birth date of deceased (mo. day, yr.)

Oct 15, 1875

## 8. AGE: Years

72

## Months

9

## Days

19

## If less than one day

hrs.

## min.

## 9. Birthplace

Italy

(Town, county, and state)

## 10. Usual occupation

Junk dealer

## 11. Industry or business

His own

## MOTHER FATHER

## 12. Name

Frances Lisanti

## 13. Birthplace

Italy

## 14. Maiden name

Antonette Reni

## 15. Birthplace

Italy

## 16. Informant

Mrs. Daniel Lisanti

## Address

126 W. 3rd St

## 17. Burial

Date thereof Aug 7, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

St. Mary's Cem.

## Location

Cumberland

## 18. Funeral director

James J. Scarpelli

## Address

Cumberland

## 19. Date rec'd by registrar

Aug 5, 1948

(Date rec'd by registrar)

W.H. Dantz M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 W. 3rd St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

August 4 1948 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 1947 to August 4 1948

and that I last saw him alive on Aug 27 1948

## Immediate cause of death

Hemangioma - Jerome  
Skin and lungs

## Due to

Hemangioma

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings or operations

Biopsy hemangioma  
excision of skin Date of op. 6-30-48

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

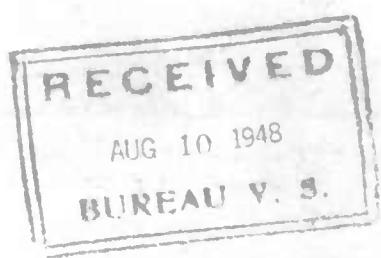
Injured at work?

## 23. SIGNATURE

A. Morris M.D.

M. D. or other

Address 57 Second St Date signed Aug 4, 1948



PLEASE WRITE PLAINLY, WITH BLACK INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07935

174

8

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegany

City or town near Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waynesburg mine #5

How long in hospital or institution? in mine 10 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Rural Ban's Mountain

(If outside city or town limits, write RURAL and give nearest town)

Street No. near Frostburg Md.

(If rural, give LOCATION)

2.(a) Is veteran, name war.

## 3.(a) FULL NAME

George Loar

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Gladys Ross \*\*\* \*Loar

7. Birth date of deceased (mo., day, yr.) Feb. 21- 1910

6.(c) If alive, give age 34 years

8. AGE: Years Months Days It less than one day

38 5 23 hrs. min.

9. Birthplace W. Va. near Pinto Md.

(Town, county, and state)

10. Usual occupation mine foreman

11. Industry or business Georges Creek Coal Co.

12. Name William Loar

13. Birthplace Lonaconing Md.

14. Maiden name Desdemona Powell

15. Birthplace Gilmore Md.

16. Informant Lind Rossi

Address Ocean, Maryland

17. Burial Date thereof Aug. 17, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing Md.

18. Funeral director J.W. Eichhoffer

Address Lonaconing, Md.

19. Date rec'd by registrar Aug. 17, 1948

(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

216-05-2904

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14

19 48 at 9 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 to 19

and that I last saw him alive on Aug. 14 19 48

Immediate cause of death Asphyxiation and 1st, 2nd &amp; 3rd degree burns all over body &amp; shock

DURATION

at

once

Due to

Coal mine explosion from coal

dust due to methane gas

Other conditions ignited from an open type mine motor (Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-14-48

Where did injury occur? Lonaconing Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in coal mine

Means of injury coal dust explosion at work? Yes

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. Father

Address Cumberland, Md.

Date signed 8-15-48

RECEIVED  
AUG 30 1948  
BUREAU F. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness  
is especially important. Physicians: please write the causes of death clearly and legibly.

*Evidence for change of  
age shown on  
this corporate limit*

FILM NO. G 117 AUG 30 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

07936

4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County. ALLEGANY.  
City or town. CUMBERLAND. (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? SIX HOURS  
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL  
How long in hospital or institution? SIX HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State. PENNSYLVANIA County. BEDFORD  
City or town. HYNDMAN (If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)

2.(a) If veteran, name war. ✓

3. (b) Social Security Number

3. (a) FULL NAME  
ELLEN BARBARA LOGSDON

4. Sex FEMALE	5. Color or race WHITE	6.(a) Single, married, widowed, or divorced WIDOWED
---------------	------------------------	---

6.(b) Name of husband or wife MOSES LOGSDON

7. Birth date of deceased (mo. day yr.) SEPTEMBER 19, 1868

8. AGE: Years 79	Months 80	Days 11	If less than one day hrs. . . . . min. . . . .
------------------	-----------	---------	--

9. Birthplace. PENNSYLVANIA  
(Town, county, and state)

10. Usual occupation. HOMEMAKER

11. Industry or business

12. Name VALENTINE EMERICK
13. Birthplace PENNSYLVANIA

14. Maiden name Mary Burkett
15. Birthplace Pennsylvania

16. Informant Mrs. Ruth Sarver
Address Hyndman, Pa.

17. Burial Comps	Date thereof. 8/23/48
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory Hyndman, Pa.
Location Hyndman, Pa.

18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. Date rec'd by registrar Aug 21 1948	Registrar Hunter R. Zeigler, M.D.
---	-----------------------------------

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20, 1948, at 7:15 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. . . . . to 19. . . . .

and that I last saw her Dead Aug. 20 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

7 hours

Due to. Fell out of bed & hit head on floor.

Due to.

Other conditions Paraplegia, 3 yrs. duration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 8-20-48

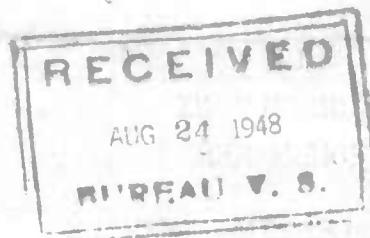
Where did injury occur? Hyndman, Bedford, Pa. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Fell out of bed. Injured at work? no 100  
deputy medical examiner

23. SIGNATURE H. V. Deming, M.D. H. V. Deming, M.D.  
M. D. or other

Address. Cumberland, Md. Date signed 8-20-48



87937

MARYLAND STATE DEPARTMENT OF HEALTH Dr. P. R. Wilson  
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County..... Allegany  
City or town..... Barton rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 55 years

Hospital, institution, or street address where death occurred:

1 mile east of Barton

How long in hospital or institution?.....

3. (a) FULL NAME

WALTER ISAAC McCLOUD

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Lucy Fink McCLOUD

7. Birth date of deceased (mo., day, yr.)..... August 15, 1880

6. (c) If alive, give age..... 43 years

8. AGE: Years	Months	Days	It less than one day
68	0	2	hrs. min.

9. Birthplace..... unknown  
(Town, county, and state)

10. Usual occupation..... miner

11. Industry or business..... coal mine

12. Name..... Hyder McCLOUD
13. Birthplace..... unknown

14. Maiden name..... Unknown
------------------------------

15. Birthplace.....
---------------------

16. Informant..... Mrs. Lucy McCLOUD
--------------------------------------

Address..... Barton, Maryland
-------------------------------

17. Burial..... Laurel Hill Cemetery
--------------------------------------

Burial, cremation, or removal. Which?.....
--

Date thereof..... August 19, 1948  
(month) (day) (year)

Cemetery or crematory.....
----------------------------

Location..... Moscow, Maryland
--------------------------------

18. Funeral director..... Ellsworth S. Boal
---

Address..... Westernport, Maryland
------------------------------------

19. Date rec'd by registrar..... Aug. 19, 1948
--

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Alleagney

City or town..... Barton - rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1 mile east of Barton  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-20-7289

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... August 16, 1948 at 10:10p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10, 1948 to Aug. 16, 1948

and that I last saw him alive on Aug. 16, 1948

Immediate cause of death..... Chronic Hypertension and Myocardial Degeneration Not Specifically

as Rheumatic

DURATION..... 2 Weeks

Due to.....

Due to.....

Other conditions..... Pulmonary and Generalized Edema

(Include pregnancy within 3 months of death) Ten Days

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

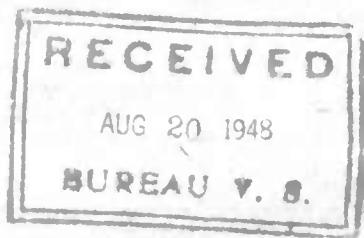
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Paul R. Wilson, M.D.

M. D. or other..... Piedmont, W. Va.

Date signed..... Aug. 18, 1948



Dr. W. F. Williams

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07938

61

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Distr. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1. PLACE OF DEATH:  
County..... Alleghany

City or town..... Cumberland, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Memorial Hospital

How long in hospital or institution? 1 day 7 hours 40 minutes

2. (a) FULL NAME  
Mrs. Phyllis M. McCreary

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced  
Married

6.(b) Name of husband or wife..... Frank F. McCreary Jr.

7. Birth date of deceased (mo., day, yr.) October 12, 1923  
..... 6.(c) If alive, give age years

8. AGE: Years 24 Months 10 Days 3 If less than one day hrs. min.

9. Birthplace..... Cumberland, Maryland  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER  
12. Name..... Robert Humbird  
13. Birthplace..... Maryland

14. Maiden name..... Helen Barger

15. Birthplace..... Maryland

16. Informant..... Memorial Hospital

Address..... Cumberland, Maryland

17. Burial..... Burial Date thereof..... 8/18/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill CEME.

Location..... Cumberland, Md.

18. Funeral director..... Louis Stein Inc.

Address..... Cumberland, Md.

19. Aug 18 1948  
(Date record by registrar) 1948  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 205 Springdale Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 15 1948 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1948, 10 AM Aug. 15 1948 and that I last saw her alive on 15 1948

Immediate cause of death.....

Due to..... Diabetes mellitus (Cause)  
Duration..... About 1 year

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op. none

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

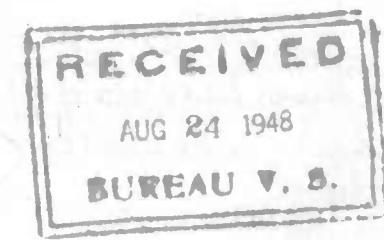
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Dr. W. F. Williams

M. Daughter

Address..... Cumberland, Maryland Date signed..... Aug 16 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07939

## CERTIFICATE OF DEATH

8

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County alleganyCity or town M' Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

charles Opner M. Gowan

## 3. (b) Social Security Number

217-05-3512

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Sara Ellen O'Rourke

7. Birth date of deceased (mo., day, yr.)

Oct. 24<sup>th</sup> 1874

6. (c) If alive, give age

8. AGE:

Years	Months	Days	If less than one day
73	9	12	hrs. min.

9. Birthplace

Scotland  
(Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

Jackson Coal Min. Lonaconing

FATHER

12. Name Samuel M. Gowan

MOTHER

13. Birthplace Scotland

14. Maiden name

Anna Elliott

15. Birthplace

Scotland

16. Informant

mrs Harry Wilson

Address

M' Midland, Md

17. Burial

Date thereof Aug. 9 1948  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Michael's Cemetery

Location

Frostburg, Md

18. Funeral director

M. Eichman

Address

Lonaconing, Md

Aug 8

19

48 Dissected

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

alleganyCity or town M' Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

8 / 6at 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947to 1948and that I last saw h. Ind. alive on 8 / 5 / 1

1948

Immediate cause of death

Coronary thromboses  
2) miners Asthma

DURATION

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

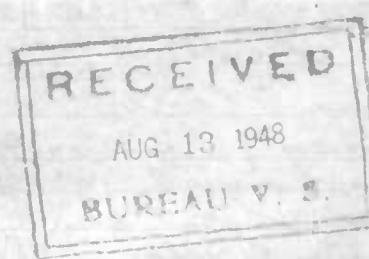
Means of injury

Injured at work?

23. SIGNATURE

Dad Eugene Dry M. D. or otherAddress Lonaconing, Md Date signed 8/7/48

STATE OF NEW YORK  
ATTORNEY GENERAL  
CITY OF NEW YORK



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

White corporate line

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:  
 County..... Allegany.....  
 City or town..... Cumberland, Md.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since birth  
 Hospital, institution, or street address where death occurred:  
 Memorial Hospital.....  
 How long in hospital or institution? 2.1/2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md..... County..... Allegany.....  
 City or town..... Cumberland.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 7 E. Elder St.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Rosemarie McGreevy

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Female white single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 7- 1942

8. AGE: Years 5 Months 10 Days 19 If less than one day hrs. min.

9. Birthplace..... Cumberland, Md.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Owen J. McGreevy.....  
13. Birthplace..... Midland Md.....

14. Maiden name..... Dorothy Spencer.....

15. Birthplace..... Staunton Va.....

16. Informant..... Owen J. Mc Greevy.....

Address..... 7 E. Elder St Cumberland Md.....

17. Burial! Date thereof..... August 30, 1948  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St. Peter &amp; Paul Cemetery.....

Location..... Cumberland, Maryland.....

18. Funeral director..... John J. Hafner.....

Address..... Cumberland, Maryland.....

19. Aug. 29, 1948.....

(Date rec'd by registrar) Hunter A. Tracy, M.D. Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 26..... 19 48, a 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her Dead Aug. 26..... 19 48.

Immediate cause of death..... Abdominal hemorrhage.....  
3 hrs. DURATION

Due to..... ruptured spleen &amp; Liver.....

Due to..... hit by an automobile.....

Other conditions..... abrasions of body &  
laceration of scalp.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... as above..... Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident..... Date of 8-26-48

Where did injury occur? Cumberland Allegany Md.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Va. Ave. near Elder

Means of Injury..... hit by an Auto. Injured at work? no

Deputy Medical Examiner - Allegany Co. Address..... Cumberland Md. Date signed 8-26-48

23. SIGNATURE..... H. V. Deming, M.D. M. D. or other

Address..... Cumberland Md. Date signed 8-26-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07941

6

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Allegany.....

City or town..... Westernport.....

(If outside city or town limits, write RURAL and give nearest town)

50 yrs

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

John F. McGuigan McGuigan

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Stella Gannon Mc Guigan

7. Birth date of deceased (mo., day, yr.) ..... 6. (c) If alive, give age..... years  
Feb. 11, 18708. AGE: Years Months Days It less than one day  
78 6 18 hrs. min.9. Birthplace..... Bartons, Allegany ?Md.  
(Town, county, and state)

10. Usual occupation..... C &amp; P.R.R.

11. Industry or business..... Retired Conductor

12. Name..... John Mc Guigan

13. Birthplace..... Md.

14. Maiden name..... Ellen Naughton

15. Birthplace..... Md.

16. Informant..... Mrs Stella McGuigan

Address..... Westernport, Md.

17. Burial..... Date thereof..... Sept. 1, 1948  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

Cemetery or crematory..... St. Peters Cemetery

Location..... Westernport, Md.

18. Funeral director..... W. Harvey Fullenkamp Jr.

Address..... Piedmont, W.Va.

19. (Date rec'd by registrar)..... Sep. 1, 1948 (Signature).....

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Allegany

City or town..... Westernport, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

Aug. 29, 1948 at 10.30 p.m.

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. .... to .....  
and that I last saw h. .... alive on Aug. 30, 1948 19....

Immediate cause of death.....

Chronic Myocarditis DURATION

several years

Due to.....

Due to.....

Other conditions Edema of Limbs.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE..... S. V. Denning M.D. M. D. or other

Address..... Cumberland Md. Date signed..... Aug. 30, 1948

RECEIVED

SEP 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

07942

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

1 Month

Now long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Andrew McKenzie

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

B. (b) Name of husband or wife Andrew Maycroft

7. Birth date of deceased (mo. day yr.) Aug 26, 1879 8. (c) If alive, give age years

8. AGE: Years Months Days It less than one day 68 11 11 hrs. min.

9. Birthplace Hazelton, Garrett Co., Md. (Town, county, and state)

10. Usual occupation Farmer Retired

11. Industry or business Town Farm

12. Name Eliza Ann McKenzie

13. Birthplace Hazelton, Garrett Co., Md.

14. Maiden name Elizabeth Elizabeth

15. Birthplace Cumberland, Md.

16. Informant Mrs. Gertrude Clegg

Address Westport

17. Burial, cremation, or removal, which? Burial Date thereof Aug 26, 1918

(month) (day) (year)

Cemetery or crematory St. Anna's Cemetery

Location Wilton, Garrett Co., Md.

18. Funeral director Mr. Bichon

Address Sonacoring, Md.

19. Date rec'd by registrar Aug 8, 1918

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 5750 S. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1918 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1918, to Aug 7, 1918,

and that I last saw him alive on Aug 7, 1918.

Immediate cause of death

Cerebral stroke with heart failure

DURATION

3 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. J. Johnson M.D. Father  
Cumberland, Md. Date signed Aug 8, 1918

RECEIVED

AUG 17 1948

BUREAU U. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W.F. Williams

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07943

93d

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or Institution? 2 days

## 3. (a) FULL NAME

Emery Britt Mc Luckie

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 11, 1900

8. AGE:

Years

Months

Days

If less than one day

48

3

8

hrs.

min.

## 9. Birthplace

Frostburg, Allegany Co., Md.

(Town, County, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Dairy Farming

MOTHER FATHER

12. Name

Andrew J. Mc Luckie

13. Birthplace

Frostburg, Md.

14. Maiden name

Alice Sabine

15. Birthplace

Frostburg, Md.

16. Informant

Mrs. Rena J. Sinyor

Address Rt. 4 Cumberland Md.

17. Burial

Date thereof Aug. 22, 1948  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Staley

Address

Cumberland, Md.

19. Aug. 22 1948

(Date rec'd by registrar)

Walter R. Tracy, M.A.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Clover Hill Farm

(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore Pike Rte 2 Cumberland

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-17-48 to 8-19-48

and that I last saw him/her on

Immediate cause of death

Cerebral Hemorrhage

Due to Chronic Hypertension

Due to Head Injury

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none none

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

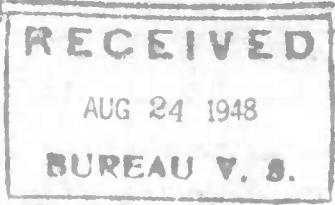
Means of injury

Injured at work?

23. SIGNATURE

W.F. Williams M. D. or other

Address Cumberland, Md. Date signed 8-10-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07944

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Allegany  
 County Cumberland  
 City or town. (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 Allegany Hospital  
 How long in hospital or institution? 4 days

3. (a) FULL NAME Loretta G. Miltenberger

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
---------------	------------------------	--

6.(b) Name of husband or wife None

7. Birth date of deceased (mo. day, yr.) Jun. 29, 1874

8. AGE: Years 74	Months 6	Days 24	If less than one day hrs. min.
------------------	----------	---------	--------------------------------

9. Birthplace Adams Co. Penna.  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business School Teacher

MOTHER FATHER 12. Name Henry Miltenberger

13. Birthplace Penna.

14. Maiden name Mary Ann Brady

15. Birthplace Penna.

16. Informant Miss. Regina Miltenberger

Address 206 Park St., Cumberland, Md.

17. Burial Date thereof Aug. 26, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S. S. Peter & Paul Cem.

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Aug. 26 1948 Hunter R. Ing, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 206 Park St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug. 23, 1948, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 19, 1948, to Aug. 23, 1948  
 and that I last saw her alive on Aug. 22, 1948

Immediate cause of death Hypertension, cerebral hemorrhage, Right  
 DURATION 5 days

Due to Hypertension

Due to Atherosclerosis

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

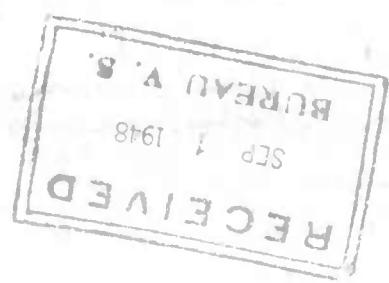
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adelle G. Miltenberger, M.D. or other

Address Cumberland, Md. Date signed Aug. 24, 1948





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07945

466

8

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs. 10 mos. 19 days.

Hospital, institution, or street address where death occurred:

Allegany Street

How long in hospital or institution?

## 3. (a) FULL NAME

Louise Vohing Muir

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

Adam Muir

7. Birth date of deceased (mo., day, yr.)

September 27 1866

8. AGE:

Years	Months	Days	If less than one day
81	10	19	✓ hrs. ✓ min.

9. Birthplace

Lonaconing Allegany Md.

(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

Conrad Vohing

12. Name

Conrad Vohing

13. Birthplace

Germany

Christina Grott

14. Maiden name

Christina Grott

15. Birthplace

Germany

Mrs. Thomas Dick

16. Informant

Lonaconing Md.

Address

Burial

Date thereof Aug. 19 1948  
(month) (day) (year)

17. Cemetery or crematory

Oak Hill

Location

Lonaconing Maryland

18. Funeral director

M. Eichhart

Address

Lonaconing Maryland

19. Date reg'd by registrar

Aug. 19 1948 Brunette M. Board

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. Allegany

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

8/16 1948 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 48 to Aug 19 48

and that last saw her alive on Aug 19 48

Immediate cause of death

metastatic Carcinomatosis  
of abdomen

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Where?)

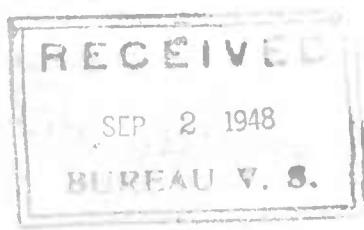
Means of injury Injured at work?

23. SIGNATURE

Paul Eugene Drey, M.D.

D. or other

Address Lonaconing, Md. Date signed Aug 19 48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07946

126

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County.....

ALLEGANY

City or town.....

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

15 DAYS

Hospital, institution, or street address where death occurred:.....

MEMORIAL Hospital

How long in hospital or institution?.....

15 DAYS

## 3. (a) FULL NAME

MRS. REBECCA S. NEVILLE

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife.....

WILLIAM W. NEVILLE

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.)

8/23/1904

8. AGE: Years

44

Months

0

Days

2

If less than one day

hrs.

min.

9. Birthplace.....

ILLINOIS

(Town, county, and state)

10. Usual occupation.....

HWFE

11. Industry or business

MOTHER FATHER

12. Name SEATON, CHARLES

13. Birthplace ILLINOIS

14. Maiden name WAYMAN, ELIXABETH

15. Birthplace W. VA.

16. Informant

Memorial Hospital

Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 29 1948

(month) (day) (year)

Cemetery or crematory

Romney Cem

Location

Romney, W. Va.

18. Funeral director

Moyl Corbin

Address

Romney, W. Va.

19. Date rec'd by registrar

An 25 1948

Walter G. Tait, M.D.

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA.

County

Mineral

City or town.....

KEYSER

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

112 WEST PIEDMONT ST.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Aug 25 - 1948 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10 1948 to Aug 25 1948

and that I last saw her alive on Aug 25 1948

Immediate cause of death

Pulmonary embolism

Due to

Hypertension

Due to

Cholera

Other conditions

Cholera

Cholangitis

23. SIGNATURE

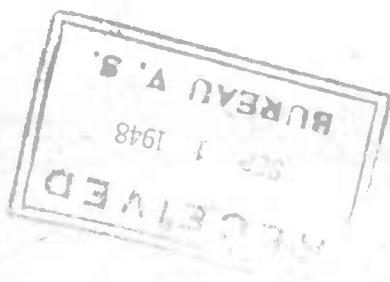
F. M. Wilson

M. D. or other

Address

Cumberland, Md

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07947

94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred

517 Greene St.

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White Married 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Margaret A. Lovell

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) Jan 15 1880

8. AGE: Years Months Days If less than one day

68 7 16 hrs. min.

9. Birthplace Pocahontas St. Va.

(Town, county, and state)

10. Usual occupation Bolt - Forge

11. Industry or business Railway

12. Name Charles K. Brownson

13. Birthplace Unknown

14. Maiden name Virginia Ogle

15. Birthplace Ind.

16. Informant Mrs. Margaret A. Brownson

Address Cumberland

17. Burial Date thereof Sept 2 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter &amp; Paul Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Sept 1, 1948 Wk Day M.D.

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number 705-07-9610

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Aug 31, 1948 to Aug 31, 1948

and that I last saw him alive on Aug 31, 1948

Immediate cause of death Coronary

Due to Thrombosis

Duration 260.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

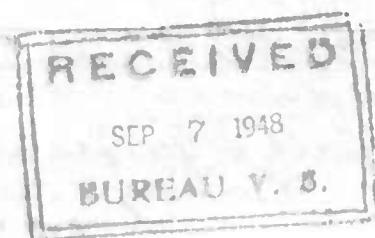
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. Williams

M. D. or other

Address Cumberland Date signed 8/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07948

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. /

## 1. PLACE OF DEATH:

County Allegany

City or town Rural Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Henry E. Norris

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male

White

Married

B. (b) Name of husband or wife Grace Rabey Norris

6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

May 13, 1869

8. AGE:

Years

Months

Days

If less than one day

79

2

28

hrs.

min.

9. Birthplace Piney Plains, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Locomotive Conductor - Retired

## 11. Industry or business

12. Name Joseph Norris

13. Birthplace Allegany Co., Md.

14. Maiden name Martha Jane Mann

15. Birthplace Allegany Co., Md.

16. Informant Mrs. Grace R. Norris

Address Little Orleans, Md.

17. Burial

Date thereof Aug. 13, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or cemetery Yonkers Cemetery

Location Piney Plain

18. Funeral director Charles R. Bast

Address Hagerstown, Md.

19. Aug. 13, 1948 Miss J. Watson  
(Date rec'd by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 10, 1948, at 12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 8, 1948, to Aug. 10, 1948

and that I last saw him alive on Aug. 10, 1948

Immediate cause of death

Chronic myocarditis

Due to

Chronic nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

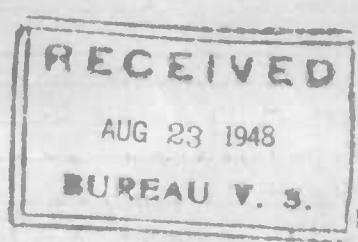
Injured at work?

23. SIGNATURE

J. M. Shaffer, M.D.

M. D. or other

Address Hancock, Md. Date signed Aug. 14, 1948



Within corporate limits

DR. FAW

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07949

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

Age  
The correct age1. PLACE OF DEATH:  
County ALLEGANYCity or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years.

Hospital, institution, or street address where death occurred:

MEMORIAL

How long in hospital or institution? 11 DAYS

3. (a) FULL NAME

WILLIAM HENRY NORRIS.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE WIDOWED

6. (b) Name of husband or wife Mary Lowery

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) JAN. 14, 1887

8. AGE: Years Months Days If less than one day  
61 6 26 hrs. min.9. Birthplace MARYLAND  
(Town, county, and state)

10. Usual occupation Construction Supt.

11. Industry or business Building trades

12. Name JOHN FENTON NORRIS.

13. Birthplace MARYLAND

14. Maiden name VIRGINIA MARGARET RUCKER.

15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL

CUMBERLAND, MD

Address

17. Burial Date thereof Aug 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Cemetery  
Location Cumberland, Md.18. Funeral director John J. Hafer  
Address Cumberland, Md.19. Aug. 12, 1948 Dr. Frank M.D.  
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County allegany

City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 466 GOETHE STREET,  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

214-05-8514

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 10 48 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 31 1948 to August 10 1948  
and that I last saw him alive on August 9 1948

Immediate cause of death

Peritonitis - diffuse

DURATION

Aug 9-10

Due to leakage - esophago -  
jejunum - stomach

One day

Due to fatal resection stomach 7 days -  
spleen and tail of pancreas

7 days

Other conditions Adens - carcinoma stomach,

obstruction and metastasis to

spleen and pancreas

(Include pregnancy within 8 months of death)

Major findings of operations Same as above

Date of op. Aug 3, 1948

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide yes

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

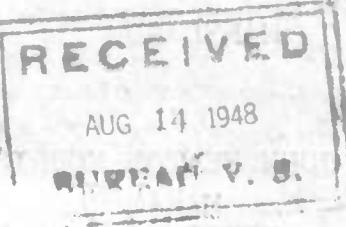
Means of injury

Injured at work?

23. SIGNATURE W. HENRY FAW JR. M.D.

M. D. or other

Address Cumberland, Md. Date signed Aug 12, 1948



07950

DR MIRKIN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 18 DAYS

## 3. (a) FULL NAME

VANCE H PARISH

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6. (b) Name of husband or wife DOROTHY DUBBS

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

NOV 20, 1905

8. AGE: Years Months Days If less than one day

42

NOV

8

16

hrs.

min.

9. Birthplace W. VA

(Town, county, and state)

10. Usual occupation CELANES

11. Industry or business DEPT 39

12. Name PARISH, CHARLES

Unknown

14. Maiden name ELLA DAVIS

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address

MEMORIAL AVE

17. Burial, cremation, or removal? Date thereof Aug. 6, 1948

(Burial, cremation, or removal). Which? (month) (day) (year)

Cemetery or crematory

Keyser Cem

Location

Keyser, W. Va.

18. Funeral director

Rogers Funeral Home

Address

Keyser, W. Va.

19. Aug. 6, 1948 (Date rec'd by registrar)

Last. Dr. Katz, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State W. VIRGINIA County MINERAL

City or town KEYSER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 71 NOZELL ST

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

217-10-7066

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 6

19. 48, at 11:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JULY, 19 1948 to AUGUST 6 1948

and that I last saw h.c.m. alive on AUGUST 5 1948

19. 48

Immediate cause of death METASTATIC MALIGNANCY

DURATION

6 Mos.

Due to CARCINOMA, PRIMARY SITE

UNDETERMINED

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations BIOPSY - ADENOCARCINOMA

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

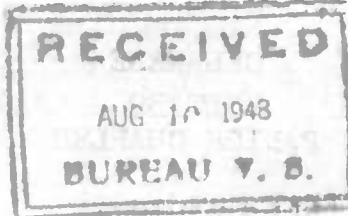
Injured at work?

23. SIGNATURE

Frank G. Bailey, M.D.

D. or other

Address Memorial Hosp. Coalfield Aug. 6, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07951

93d

4

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hosp.

How long in hospital or institution?

## 3. (a) FULL NAME

Charles T. Peer.

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

Unknown

## 7. Birth date of deceased (mo. day, yr.)

Unknown abt 1897

## 8. AGE:

71

Years

&gt;

Months

2

Days

3

If less than one day

hrs.

min.

## 9. Birthplace

Romney W. Va.

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

Hampshire Peer.

## 12. Name

Hampshire Peer.

## 13. Birthplace

W. Va.

## 14. Maiden name

Unknown

## 15. Birthplace

"

## 16. Informant

W.H. McKee

## Address

Augusta W. Va.

## 17. Cemetery or crematory

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 9 '48

(month) (day) (year)

## Location

New Romney W. Va.

## 18. Funeral director

Locie Lee

## Address

Cumberland MD

## 19. Date rec'd by registrar

Aug 9 1948

W.L. Fahey M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

Md.

## County

allegany

## City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

100

Haig Ave.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Aug 9 1948 at 8:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 9 1948 to Aug 9 1948

and that I last saw him alive on Aug 9 1948

Immediate cause of death

Hemiplegia

## Due to

Hypertension C.V. Disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

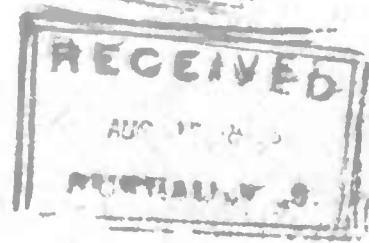
Injured at work?

## 23. SIGNATURE

B.M. Chandler, M.D.

M.D. or other

Address 41 Incent St. Date signed Aug 9 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07952  
91

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death?.....

Hospital, institution, or street address where death occurred.....

Address.....

How long is hospital or institution?.....

## 3. (a) FULL NAME

Gilbert P. ...

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Sarah L. ...

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age..... years

Nov 19 - 1872

8. AGE:

Years

Months

Days

If less than one day

75 8 16 hrs. min.

9. Birthplace

Frostburg, Allegy. Md.

(Town, County, and state)

10. Usual occupation

Retired Coalmines Worker

11. Industry or business

Commody. Coal

12. Name

Conrad A. ...

13. Birthplace

Frostburg, Md.

14. Maiden name

Tempy Dickey

15. Birthplace

Frostburg, Md.

16. Informant

John G. ...

17. Burial

Address 146 Washington St Frostburg

(Burial, cremation, or removal. Which?)

Date thereof Aug - 8 - 1948

(month) (day) (year)

Cemetery or crematory

Oakhurst Cemetery

Location

Oakhurst, Md.

18. Funeral director

Jacob ...

Address

Frostburg, Md.

19. 8-5

1948 Mrs. Harry V. ...

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 55

Locality Frostburg

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

215-10-4463

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

August 5 1948 at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 1948 to Aug 5 1948 and that I last saw him alive on Aug 5 1948

Immediate cause of death

Cerebral hemorrhage

Due to

C-V-R disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Meas of injury

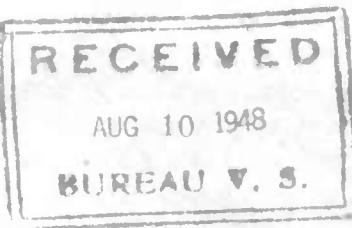
Injured at work?

## 23. SIGNATURE

W.E. Gallegos M.D.

M. D. or other

Address Frostburg, Md. Date signed 8/6/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits  
M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07953

## CERTIFICATE OF DEATH

Reg. Diet. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 4 Days

## 3. (a) FULL NAME

Miss Elmire. Piper

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
------------------	---------------------------	--

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years  
Aug. aug 9. 18 44

8. AGE: Years Months Date If less than one day

64 18 hre. min.

9. Birthplace Oldtown, Maryland  
(Town, county, and state)

House Work

10. Usual occupation

11. Industry or business

MOTHER FATHER	12. Name Ezekial Piper
	13. Birthplace Maryland

MOTHER	14. Maiden name Martha. Wagenr
FATHER	15. Birthplace nebraska

16. Informant Memorial Hospital  
Address Cumberland Md17. Burial Date thereof Aug 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hardsocks.  
Location Near Oldtown, Md  
Wolford.s Funeral Home18. Funeral director  
Address 125 S Liberty St  
Cumberland Md19. Aug 27 1948 Winter R. P. m  
(Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegy

City or town Oldtown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 22 1948 to Aug. 26 1948 and that I last saw her alive on Aug. 26 1948

Immediate cause of death Left cerebral hemorrhage  
Left Hemiplegia  
ParalysisDue to...  
" " "Due to...  
" " "Other conditions...  
(Include pregnancy within 8 months of death)Major findings of operations...  
Date of op.Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

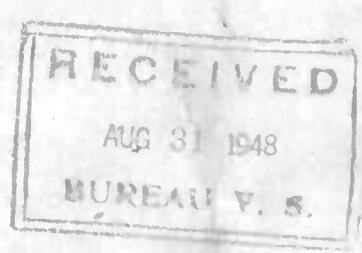
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Capt. Ferrell  
M.D. or other

Address Cumberland, Md Date signed Aug 27, 1948



Within corporate limits

Richard Williams

07954

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumb'land

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 day

## 3. (a) FULL NAME

Edgar Van Meter Pratt

## 4. Sex

M

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Eliza E. Messick

6.(c) If alive, give age 68 years

## 7. Birth date of deceased (mo., day, yr.)

March 10, 1886

## 8. AGE:

62

Years

Months

Days

If less than one day

4

29

hrs.

min.

## 9. Birthplace

Marefield, W. Va.

(Town, county, and state)

## 10. Usual occupation

Retired - B. &amp; O. Engineer

## 11. Industry or business

Railroad

## MOTHER FATHER

## 12. Name

Jacob Pratt

## 13. Birthplace

W. Va.

## 14. Maiden name

Susan Sherman

## 15. Birthplace

W. Va.

## 16. Informant

Mrs. May Bishop

## Address

Narrows, Va.

Burglary

Burial, cremation, or removal. Which?

Date thereof August 12, 1948

(month) (day) (year)

## Cemetery or crematory

Mt. Herman Cemetery

## Location

Cumberland, Md.

## 18. Funeral director

John J. Hooper

## Address

Cumberland, Md.

## 19. Date rec'd by registrar

Aug. 11, 1948

1948

W. L. Daugherty

Registrar

VS A15 9-45-15M

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Tpt. 2, Williams Road

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

705-05-4560

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948, at 9:30 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to Aug. 9, 1948

and that I last saw him alive on Aug. 9, 1948

19

Immediate cause of death Chronic Myocarditis

Duration 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE M.D. or other

Address

Signed 8/11/48

RECEIVED  
AUG 17 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07955

8

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Allegany

City or town

Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs 11 mos 19 days

Hospital, Institution, or street address where death occurred:

State Street

How long in hospital or institution? ✓

## 3. (a) FULL NAME

Willis Weston

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Wessel Ryan Weston

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

August 21, 1888

8. AGE: Years Months Days If less than one day

59 11 19 hrs. min.

9. Birthplace Lonaconing Allegany Maryland

(Town, County, and state)

10. Usual occupation Miner (Retired)

11. Industry or business Lonaconing Coal Co.

12. Name William Weston

13. Birthplace Barton Maryland

14. Maiden name White

15. Birthplace Unknown

16. Informant Mrs. Irene Weston

Address Lonaconing Md.

17. Burial Date thereof Aug. 14, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lake Hill Cemetery

Location Lonaconing Md.

18. Funeral director M. Eichhorn

Address Lonaconing Md.

19. Aug. 14 1948 Jannette M. Boal

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

220-10-2368

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h. alive on 19.....

Immediate cause of death

Coronary thrombosis

DURATION

Due to Atherosclerotic vascular disease

Due to Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

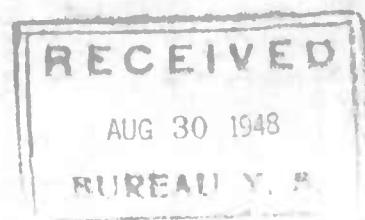
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Paul Eugene Dry, M.D.

M. D. or other

Address Lonaconing Md. Date signed 8/13/48



Within corporate limits

DR E. WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1918

07950

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 20 DAYS

## 3. (a) FULL NAME

MRS BERTHA PRINCE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife

CHARLES PRINCE

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo. day. yr.)

NOV 7 1872

8. AGE:

75

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

MARYLAND, Cumberland, Alleg Co.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

Our Home

CHESTER CRISTY James

MOTHER FATHER

12. Name

MARYLAND, Cumberland

13. Birthplace

REBECCA JACKSON Sarah

MOTHER

FATHER

14. Maiden name

MARYLAND, Cumberland

15. Birthplace

MEMORIAL HOSPITAL

MEMORIAL AVE

Date thereof Aug 4 1948

Date thereof Aug 4 1948

(Burial, cremation, or removal, if applicable)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

John Dr. Taylor

Address Cumberland, Md

Date Aug 12 1948

W.R. Fahey M.D.

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 54 MARION ST

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

Rose

## MEDICAL CERTIFICATION

2D. DATE OF DEATH AUG 11 1948 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov 15 1948 10:00 AM 1948

and that I last saw her alive on 8/11/48 1948

Immediate cause of death

Hypertension

underlying cause Chronic nephritis

Causes leading to death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE DR E. WILLIAMS M.D. or other

Address DR E. WILLIAMS M.D. Date signed

RECEIVED

AUG. 17 1948

BUREAU U. S.

RECEIVED

AUG 17 1948

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07957

8

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

Margaret Barclay Rosten

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Haggard

6. (b) Name of husband or wife.....

Henry Rosten

7. Birth date of deceased (mo., day, yr.)

Aug. 25, 1870

6. (c) If alive, give age ..... years

8. AGE:

Years      Months      Days      If less than one day

.... hrs. .... min.

9. Birthplace.....

England, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Own Home

MOTHER

FATHER

12. Name.....

Robert Barclay

13. Birthplace.....

Scotland

14. Maiden name.....

Mary Frazier

15. Birthplace.....

Nova Scotia

16. Informant.....

Mrs. Mabel R. Evans

Address

1356 Foothill Blvd., Altadena, California

17. Burial, cremation, or removal, Which?

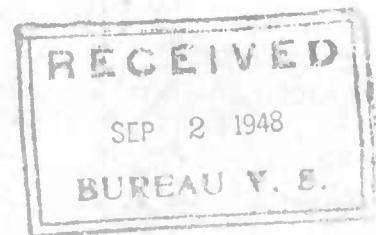
Date thereof Aug. 29, 1948

(month) (day) (year)

(month)

(day)

(year)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. [unclear] 07950  
13a

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County

City or town

Allegany

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9 mt. Pleasant St.

How long in hospital or institution?

## 3. (a) FULL NAME

Robert Gracie Rankin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Annie Rankin

7. Birth date of deceased (mo., day, yr.)

May 30, 1888

6. (c) If alive, give age 54 years

8. AGE:

Years Months Days It less than one day

60

2

12

hrs. min.

9. Birthplace

Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation

Inspector

11. Industry or business

Packard Motor Car Co.

MOTHER FATHER

12. Name Alex Rankin

13. Birthplace

Maryland

14. Maiden name

Katherine McCready

15. Birthplace

Scotland

16. Informant

Mrs. John Geis

Address

Frostburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 15, 1948

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Burst

Address

Frostburg, Md.

19. Date rec'd by registrar

8-14-48 Mrs. Stanley N. Rose

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Michigan

County

Wayne

City or town Detroit

13

Street No. 7632 Midbury

(If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (b) Social Security Number

382-05-0251

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 12 1948 at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-12 1948 to 8-12 1948

and that I last saw him alive on 8-11 1948

Immediate cause of death

respiratory failure

DURATION

Due to

pulmonary tuberc. (2)

2

Due to

possibly septicosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

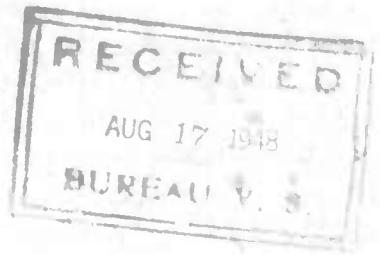
Sollef Wolverton M.D.

M. D. or other

Address

Frostburg

Date signed 8-14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct page is especially important. Physicians; please write the causes of death clearly and legibly.

*Dr. Cooper*  
Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07950

159

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 2 days

## 3. (a) FULL NAME

Velvet Love Reckley

## 4. Sex

F

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age years

## 7. Birth date of deceased (mo. day. yr.)

August 17, 1948

## 8. AGE: Years

0

Months

0

Days

2

If less than one day

hrs.

min.

## 9. Birthplace

Cumberland, Allegany, Md.

(Town, county, and state)

## 10. Usual occupation

Infant

## 11. Industry or business

12. Name Hartley M. Reckley13. Birthplace Cumberland, Md.14. Maiden name Shirley A. Seabaldt15. Birthplace Oldtown, Md.16. Informant Hartley M. ReckleyAddress Route 4, Cumberland, Md.17. Burial Date thereof August 21, 1948  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory Mt. Calvary CemeteryLocation Nr. Cumberland, Md.18. Funeral director John J. HofferAddress Cumberland, Md.19. Date rec'd by registrar August 19, 1948W.R. Trotter, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 4 Box 286

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

17 Aug 1948, to 17 Aug 1948and that I last saw her alive on 19 Aug 1948

Immediate cause of death

ATELECTASIS

DURATION

2 daysDue to Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. Steadman, M.D.

M. D. or other

Address 101 S. Centre St. Date signed 20 Aug 48

RECEIVED

AUG 24 1948

BUREAU F. B. I.

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 MINUTES

Hospital, institution, or street address where death occurred:

MEMORIAL Hospital

How long in hospital or institution? 40 MINUTES

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Near CUMBERLAND, Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. BOX 435 ROUTE #1

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

LURELLA SUSAN REED

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6.(b) Name of husband or wife ELLSWORTH REED

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1872  
6.(c) If alive, give age 68 years8. AGE: Years Months Days If less than one day  
75 10 17 hrs. min.9. Birthplace W. VA. Philippi  
(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name ROBINSON, LOUIS WILSON

13. Birthplace W. VA. HANNAH

14. Maiden name HATHAWAY, HANNAH

15. Birthplace W. VA.

16. Informant TROY T. MARKS

Address Rt. #1 Cumberland, Md.

17. Burial Date thereof Aug. 26, 1948  
(Burial, cremation, or removal, Which?)

Cemetery or crematory Mary's Chapel Cem.

Location Near Grafton, W. Va.

18. Funeral director H. WAYNE GEORGE

Address Cumberland, Md.

19. Aug. 26, 1948  
(Date rec'd by registrar) Hunter A. Frost, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/30, 1948, to 8/23, 1948

and that I last saw her alive on Aug. 23, 1948

Immediate cause of death Rupture of

lung abscess of right

lung into pleura

Due to Lung abscess

Jobar pneumonia

Due to

Other conditions Astenodema

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 122 Bedford St., Cumberland Date signed 8/27/48



McLean.  
Within corporate limits

07961

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH: Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

502 Rose Hill Ave.,

How long in hospital or institution?

## 3. (a) FULL NAME

GENEVIEVE D. REINHART

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

None

## 6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day yr.) July 13, 1875

## 8. AGE: Years

73

Months

0

Days

19

If less than one day

hrs.

min.

9. Birthplace Cumberland, Allegany, Md.  
(Town, county, and state)

## 10. Usual occupation

Retired  
C. & P. Telephone Employee

## 11. Industry or business

John Reinhart

## MOTHER FATHER

12. Name

Maryland

13. Birthplace

Lucinda Downey

14. Maiden name

Maryland

15. Birthplace

Michael D. Reinhart

Address

502 Rose Hill Ave., Cumberland,

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 4 1948

(month) (day) (year)

S. S. Peter &amp; Paul

Cemetery or crematory

Cumberland, Md.

Location

H. Wayne George

18. Funeral director

Cumberland, Md.

Address

Aug. 3 1948

(Date rec'd by registrar)

19. M. D. or other

Signature

Address

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 Rose Hill Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

212-03-6272

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2,

48 19 4:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21

1948

to

July 21st

and that I last saw her alive on

Immediate cause of death

Hyperthyroid Circulus  
Chronic Myocarditis

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

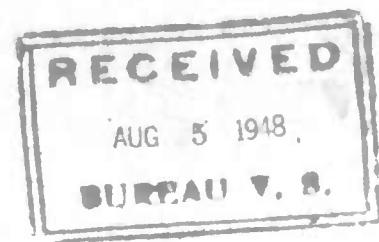
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



## Dr. W.F.WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07962  
1246

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

40 DAYS

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

40 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

ALLEGANY

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.

218 DAVIDSON STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

AUGUST 13,

1948, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that deceased from

9-20-46 to

8-13-48

1948

and that I last saw him alive on

Immediate cause of death

Corrosion

DURATION

Due to

Sepsis.

But to

Chronic Bronchitis

Heart Disease

Other conditions

Paroxysmal

(Include pregnancy within 3 months of death)

Major findings of autopsy

Paroxysmal

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

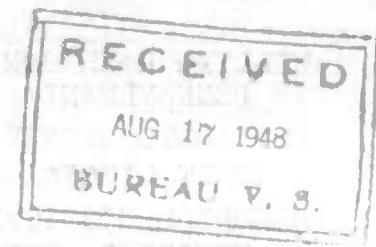
23. SIGNATURE

W.F. Williams

M. D.

Cumberland 8-13-48

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07963  
1602

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany

City or town McCooole, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

93 Maryland Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Infant Riggleman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 7, 1948

8. AGE: Years

Months

Days

If less than one day

3 hrs.

min.

9. Birthplace McCooole, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Walter Riggleman

FATHER 12. Name Keyser, W.Va.

13. Birthplace

Dorthe Foltz

MOTHER 14. Maiden name

Keyser, W.Va.

15. Birthplace

Walter Riggleman

16. Informant

Address McCooole, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 8-7-48

(month) (day) (year)

Cemetery or crematory Queenspoint

Location Keyser, W.Va.

18. Funeral director N. Howard Rogers

Address 85 S. Main St. Keyser, W.Va.

19. Aug. 25, 1948 (Date read by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town McCooole

(If outside city or town limits, write RURAL and give nearest town)

Street No. 93

Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1948 19 48 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7, 1948 19 to

and that I last saw him alive on Aug. 7 19 48.

Immediate cause of death

Prematurity

DURATION

Due to breech presentation  
ruptured membranes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1115148

Date signed

RECEIVED  
AUG 26 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07964

## CERTIFICATE OF DEATH

8

Reg. Dist. No.

97

## 1. PLACE OF DEATH:

County.....

City or town.....

Allegany  
Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

68 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Drucilla Poote Robertson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Joseph G. Robertson

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Oct 19, 1860

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Lonaconing, Allegany Co., Md.

10. Usual occupation

Housework

11. Industry or business

Own home

MOTHER FATHER

12. Name

George Poote

13. Birthplace

England

14. Maiden name

Elizabeth Buckle

15. Birthplace

England

16. Informant

Jos. Richard Elliott

Address

Midland, Md.

17. Burial

Date thereof Aug 26, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Old Cemetery

Location

Lonaconing, Md.

18. Funeral director

John C. Johnson

Address

Lonaconing, Md.

19. Date record by registrar

Aug 26 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Maryland County Allegany

City or town.....

Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 23 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/20 1948 to 8/23 1948

and that I last saw her alive on 8/23 1948

Immediate cause of death

Uremia underlying cause

nephritis resulting from

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Paul Eugene Drye, M.D.

or other

Address

Lonaconing, Md.

Date signed

8/25/48

RECEIVED

SEP 2 1948

BUREAU V. S.

I

Side of  
City Limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07965

97

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

Address R.D. #2, Cumberland, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs.

Hospital, institution, or street address where death occurred:

R.D. #2 Baltimore Pk., Cumberland, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

James Martin Ryan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife Mary A. McGuire

6. (c) If alive, give age years

7. Birth date of

deceased (mo. day, yr.) Nov. 1. 1869

8. AGE:

Years

Months

Days

If less than one day

78

9

11

hrs.

min.

9. Birthplace

West Virginia

(Town, County, and state)

10. Usual occupation

Machine

11. Industry or business

B&amp;O Railroad

12. Name

John Ryan

13. Birthplace

Ireland

14. Maiden name

Delia Noon

15. Birthplace

Ireland

16. Informant

Mrs. O.N. Magruder

Address R.D. #2 Cumberland, Md.

17. Burial

Date thereof Aug. 11 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Calvary Cemetery

Location

Grafton, W. Va.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19. Date rec'd by registrar

Aug. 12 1948

(Date rec'd by registrar)

Walter R. Long, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town R.D. #2 Cumberland, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore Pk.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 12

1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to August 1948, and that I last saw him alive on July 28, 1948.

Immediate cause of death

Semi-lute with pectoral's

Cerebral arteriosclerosis

DURATION

3 yrs

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

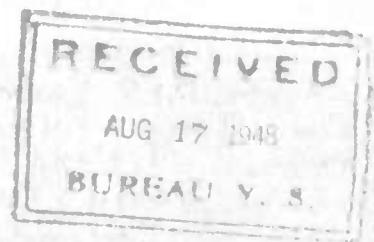
Injured at work?

23. SIGNATURE

Walter R. Long, M.D.

M.D. or other

Address Cumberland, Md. Date signed Aug. 12, 1948





*Outside of  
limits*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07966

## CERTIFICATE OF DEATH

Reg. Diet. No. 4

## 1. PLACE OF DEATH:

County... *Allegheny*City or town... *Cumberland, Md.*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *29 years*Hospital, Institution, or street address where death occurred:  
*Marrow's Park*How long in hospital or institution? *✓*

## 3. (a) FULL NAME

*Isabel Green*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female White**Single*6. (b) Name of husband or wife. *✓*7. Birth date of deceased (mo., day, yr.) *Sept. 12, 1887*6. (c) If alive, give age *✓* years8. AGE: Years *60* Months *11* Days *13* If less than one dayhrs. *min.*9. Birthplace *Massachusetts* *Allegheny Co., Md.*  
(Town, county, and state)10. Usual occupation *School Teacher*11. Industry or business *Johnson's High School*12. Name *Joseph L. Green*13. Birthplace *England*14. Maiden name *Jessie Robertson*15. Birthplace *Longsorina, Md.*16. Informant *Mrs. Ernest Green*Address *215 Marrows Park, Cumberland*17. Burial *Burial* Date thereof *Aug. 28, 1948*(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Hillcrest Burial Park*Location *Cumberland, Md.*18. Funeral director *M. Eichhorn*Address *Germacorina, Md.*19. Date reg'd by registrar *Aug. 30, 1948*(Date reg'd by registrar) *Walter P. Bent M.D.*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland*County... *Allegheny*City or town... *Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *215 Marrows Park*

(If rural, give LOCATION)

2.(a) Is veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

*Aug. 25 48 at 5 p.m.*20. DATE OF DEATH *Aug. 25, 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan. 1 47 to Aug. 21 48*and that I last saw her alive on *Aug. 18, 1948*Immediate cause of death *Pulmonary Embolism*Duration *1/2 hr.*Due to *Tumor of lung*

1/2 yrs.

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury...

Injured at work?

23. SIGNATURE *V. H. Gleason Jr.* M. D. or otherAddress *156 Main Street, Cumberland, Md.* Date signed *Aug. 1948*

RECEIVED

AUG 31 1948

BUREAU V. S.

DR. ELIASON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07967

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL, CUMBERLAND, MD.

How long in hospital or institution? 1 DAY

## 3. (a) FULL NAME

BETTY LOU SHAFFER

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE WHTEE

SINGLE

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/14/47

8. AGE: Years

Months

Days

If less than one day

hrs. min.

11 MOS

WEST VIRGINIA

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name HARRY R. SHAFFER

13. Birthplace

W.VA.

14. Maiden name

THELMA I. JOHNSON

15. Birthplace

W.VA.

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 24 48

(month) (day) (year)

Cemetery or crematory

Terra Alta

Location

Terra Alta W Va

18. Funeral director

G. F. Collins

Address

Terra Alta W Va

19. Date rec'd by registrar

Aug 24

19 48

Walter A. Gandy, M.A.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA Couly PRESTON

City or town TERRA ALTA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 24

19 48

at 10:10A

21. I CERTIFY That death occurred on the date above stated, that I attended deceased from

Aug 24 48 to Aug 24 48

and that I last saw h. ex. alive on Aug 24 48

Immediate cause of death

Intestinal Obstruction

DURATION

Today

Due to

Fecal Impaction

Wks.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Intestinal obstruction

Date of op.

Autopsy results

Intestinal Obstruction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.W. Gleason, M.D., F.A.C.P.  
126 Broad Street, Cumberland, Md.

Date signed

RECEIVED

AUG 31 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07968

## CERTIFICATE OF DEATH

46d  
Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

4 Weeks

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

4 Weeks

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs Theodra S. Shaffer

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Elzie A Shaffer

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 29 1887

8. AGE: Years Months Days If less than one day  
61 3 6 hrs. min.9. Birthplace Cumberland Allegany Md.  
(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Edward A Clark

13. Birthplace Maryland

14. Maiden name Emma Rosswurm

15. Birthplace Maryland

16. Informant Elzie A Shaffer

Address 515 Fayette St

17. Burial Date thereof Aug 7 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S.S. Peter &amp; Paul

Location Fayette St. Cumberland Md.

18. Funeral director H. Wayne George

Address Cumberland Md.

19. Aug 6 1948 W.R. Dailey M.D.  
(Date rec'd by Registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4,

1948 at 3:22P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 4, 1948, to Aug 4, 1948

and that I last saw her alive on Aug 4, 1948

Immediate cause of death

Carcinoma Rectum

DURATION

3 mo.

Due to

Due to

Other conditions

3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of Rectum

Bladder absent

Date of op. 7-26-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

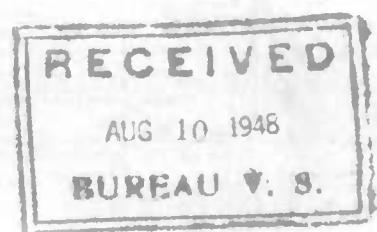
Means of injury

Injured at work?

23. SIGNATURE

O.C. Zimmerman M. D. or other

Address Cumberland Date signed 8-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07963

131a

4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1454

## 1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

life

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

601 Piedmont Avenue

How long in hospital or institution?.....

## 3. (a) FULL NAME

MRS. KATHERINE SHANHOLT

4. Sex ..... 5. Color or race ..... 6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife..... Aga. H. Shanholz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo. day, yr.) ..... June 28, 1866

8. AGE: Years ..... Months ..... Days ..... It less than one day  
81 1 7 hrs. min.9. Birthplace ..... Cumberland, Allegany, Maryland  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name ..... Leonart Shertzer

13. Birthplace ..... Germany

14. Maiden name ..... Barbara Hopach

15. Birthplace ..... Germany

16. Informant ..... Walter C. Shanholz

Address ..... 601 Piedmont Ave. Cumberland, Md.

17. Burial ..... Date thereof Aug. 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Rose Hill Cemetery

Location ..... Cumberland, Maryland

18. Funeral director ..... William H. Kight

Address ..... Cumberland, Maryland

19. Aug. 7, 1948 (Date rec'd by registrar) W.R. Frank, M.D. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 Piedmont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH ..... August 5 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to Aug. 5, 1948 and that I last saw her alive on Aug. 5, 1948

Immediate cause of death

Cardiac Arrest

DURATION

6 hrs

Due to Hypertension Heart disease and years

Due to Arteritis and years

Other conditions

Sister

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

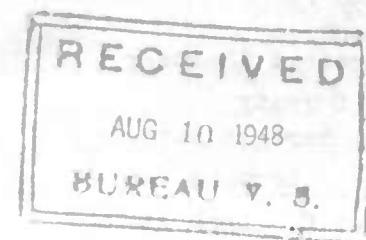
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE..... F. Alan G. Murray, M.D. or other

Address ..... Cumberland, Md. Date signed Aug. 7, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

Evidence for change of  
age shown on:  
H.M. No. G 117 SEP 23 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07970  
127a  
4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany  
City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

10 hrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital  
10 hrs.

How long in hospital or institution?

3. (a) FULL NAME

Harry Ellsworth Smeak

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lily Purbaugh

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

10/11/1887

8. AGE:

60

Years  
61

Months  
9

Days  
23

If less than one day

hrs. min.

9. Birthplace

Hyndman, Pa.

(Town, county, and state)

10. Usual occupation

B & O R.R. Co. Employee

11. Industry or business

Jacob Smeak

MOTHER FATHER

12. Name

Pa.

13. Birthplace

Lily Purbaugh Martha Dogson

MOTHER

14. Maiden name

Pa.

15. Birthplace

Pa.

16. Informant

Russel Smeak  
Hyndman, Pa.

Address

Purial Date thereof 8/7/1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Hyndman Cemetery

Cemetery or crematory

Hyndman Pa.

Location

Harvey H. Zeigler

18. Funeral director

Hyndman, Pa.

Address

Aug. 6 1948

(Date rec'd by registrar)

Mark Trautz, M.D.  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Penna. County..... Bedford

City or town..... Hyndman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 4 1948 at 9:15 AM

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from

Aug 1 1948 to Aug 4 1948

and that I last saw him alive on Aug 4 1948

Immediate cause of death

acute congestive heart 1 day

Due to

Due to

Other conditions

acute cholecystitis 1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

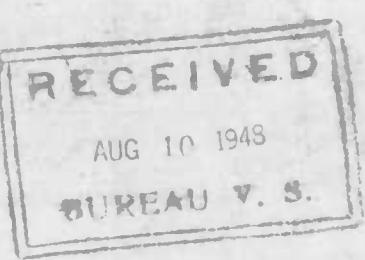
Injured at work?

23. SIGNATURE

John A. Lopper MD  
Hyndman, Pa. 8/4/48

M. D. or other

Date signed



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07971

174

8

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Allegany

City or town..... near Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waynesburg Mine #5

How long in hospital or institution? In mine 10 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Zihlman

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D.2 Frostburg Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

214-01-0090

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14

19. 48 at 9. 30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to 19. , 1948

and that I last saw h. i.m. Dead Aug. 14  
 Immediate cause of death. Asphyxiation and  
 1st, 2nd & 3rd degree burns of face  
 head & hands. 1st burns of back once.  
 D. & shock.

Coal mine explosion from coal  
 dust due to methane gas ignited  
 Other conditions from an open type mine motor  
 (Include pregnancy within 8 months of death)  
 1914-8 also

Major findings of operations.

Date of op.

## Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 8-14-48

Where did injury occur? near Lonaconing Allegany Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in coal mine

Means of Injury Coal dust explosion Did work? yes

Deputy Medical Examiner Allegany Co. M. D. or other

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 8-15-48

19. 8-17

1948

Janet M. Bol

Registrar



I

PLEASE WRITE PLAINLY, WITH BLACK INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07972

## CERTIFICATE OF DEATH

93d  
Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

allegany

2 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

9 Ormond St.

How long in hospital or institution?

## 3. (a) FULL NAME

John Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

married

6. (b) Name of husband or wife

Eva Smith

7. Birth date of deceased (mo., day, yr.)

July 12 - 1876

6. (c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

72 0 30 hrs. min.

9. Birthplace

Frostburg alleg-md

(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Hazardwood Contracting Co.

MOTHER FATHER

12. Name

John Smith

13. Birthplace

E. S.A.

14. Maiden name

Ann Faraday

15. Birthplace

Frostburg md

16. Informant

Charles Smith

Address

Route 1 - Cumberland, md

17. Burial

Date thereof Aug 14 - 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

allegany

Location

Frostburg

18. Funeral director

J. C. Almy

Address

Frostburg

19. Date rec'd by registrar

8-14 1948 Mr. Dauncy W. Ross

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

allegany

City or town

Co.

Cumberland

allegany

Street No.

600

Central Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

214-07-0191 ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 11 1948 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 1947 to Aug 11 1948

and that I last saw him alive on Aug 11 1948

Immediate cause of death

Chv Myocarditis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

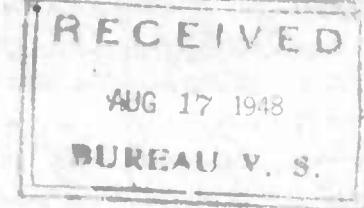
23. SIGNATURE

M. D. or other

Address Date signed

Registrar

8-13-48



DR. FAW

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07973

181

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

143 DAYS

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 143 DAYS

## 3. (a) FULL NAME

MR. RUSSELL STECKMAN

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

MARRIED

## 6.(b) Name of husband or wife

STELLA CLINGERMAN

6.(c) If alive, give age 53 years

## 7. Birth date of deceased (mo., day, yr.)

SEPTEMBER 14, 1888

## 8. AGE:

Years  
59Months  
11Days  
11If less than one day  
hrs. min.

## 9. Birthplace

PENNSYLVANIA, Bedford Co.  
(Town, county, and state)

## 10. Usual occupation

FARMER

## 11. Industry or business

## MOTHER FATHER

12. Name FRANK STECKMAN

13. Birthplace PENNSYLVANIA

## 14. Maiden name

MARY PENNELL  
PENNSYLVANIA

## 15. Birthplace

## 16. Informant

MEMORIAL HOSPITAL

## Address

MEMORIAL AVENUE

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 27, 1948  
(month) (day) (year)

## Cemetery or crematory

Fairview Cem.

## Location

Near Artemas, Penna.

## 18. Funeral director

H. Wayne George  
Address Cumberland, Md.19. Aug. 27, 1948  
(Date rec'd by registrar)Walter R. Faw, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County FULTON

City or town AMARANTH

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 25, 1948, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 4, 1948, to Aug. 25, 1948

and that I last saw him alive on August 24, 1948

Immediate cause of death

Septacessa  
secondary

Due to severe 3rd degree burns both legs, gluteal

Due to region, abdominal and  
lungs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Accident Date of April 4, 1948

Where did injury occur Little Orleans Allegany red.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury breaking glass Injured at work? No

## 23. SIGNATURE

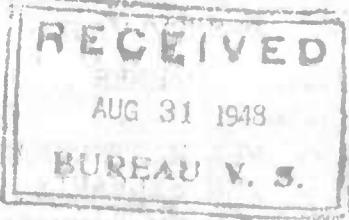
W. Wayne George, M.D.  
Cumberland, Md. Date signed Aug. 27, 1948

M. D. or other

Address

Date signed Aug. 27, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



WITHIN CIRCLES ITALIC

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07974

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County.....

*Allegany*

City or town.....

*Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

605 Lincoln Street

How long in hospital or institution? About 10 yrs.

## 3. (a) FULL NAME

*Mrs Mary Sternor*

## 3. (b) Social Security Number

None

4. Sex

*F*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*Married*

6. (b) Name of husband or wife

*Burd Sternor*

6. (c) If alive, give age.....years

7. Birth date of deceased (mo. day. yr.)

April 4, 1874

8. AGE:

Years  
74Months  
4Days  
3If less than one day  
hrs. .... min.

9. Birthplace.....

Pennsylvania  
(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

John Snyder

13. Birthplace.....

Pennsylvania

14. Maiden name.....

Sarah Haines

15. Birthplace.....

Pennsylvania

16. Informant.....

Mrs. Schumacker

Address

605 Lincoln Street, City.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Aug. 10, 1948*  
(month) (day) (year)

Cemetery or crematory

*Charles Baker Cemetery*

Location

*Pottsville, Penna*

18. Funeral director.....

*Charles J. Lloyd*

Address

*Pottsville, Penna.*19. *Aug. 8, 1948* (Date rec'd by registrar)W. J. Frantz M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Allegany

City or town.....

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

605 Lincoln Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Aug 7*

19 48 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to Aug 7 19 48

and that I last saw her alive on *Aug 6, 1948*

Immediate cause of death

*Arteria &  
Inflammation  
of heart &  
lungs*Due to *Arteria &  
Heart Disease*Due to *Chronic Hepatitis*

DURATION

*14 days**5 days*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

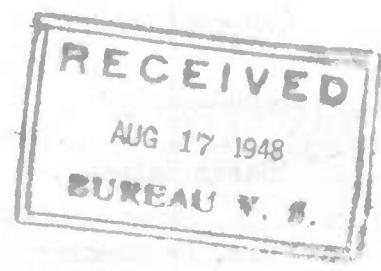
Injured at work?

23. SIGNATURE

*F. Alan G. Murray M.D.*

M.D. or other

Address *Cumberland, Md.* Date signed *Aug 7/48*



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness  
is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07975

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Lumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yrs.Hospital, institution, or street address where death occurred:  
Brenninal Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jas. Wallace Stewart7. Birth date of deceased (mo. day, yr.) Sept 22 1899 6. (c) If alive, give age ..... years8. AGE: Years 48 Months 10 Days 25 If less than one day9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Allan B. Johnson

13. Birthplace

14. Maiden name Marta Parker

15. Birthplace

16. Informant J. W. StewartAddress Lumberland17. Burial, cremation, or removal, Which? Burial Date thereof Aug 18 48  
(month) (day) (year)Cemetery or crematory Midway Cem.Location Midway Pa.18. Funeral director Lewis Stein JrAddress Lumberland Ind.19. Aug 18 48 Tented & Guarded  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County AlleganyCity or town Lumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 302 Allegany St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 17 19 48 at 11:37 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 5 19 48 to Aug 17 19 48  
and that I last saw her alive on Aug 17 19 48Immediate cause of death Pneumonia & TuberculosisDue to Diabetes Necessita

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury .....

Injured at work? .....

23. SIGNATURE C. A. Gleathman M. D. or other .....Address 49 Green St Date signed 8/18/48

RECEIVED

AUG 24 1948

BUREAU V. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07976

Within corporate limits -

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

allegany Hospital

How long in hospital or institution?

4 days

## 3. (a) FULL NAME

Benjamin Arthur Strawderman 3. (b) Social Security Number 223-14-2396

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Mary Johnston7. Birth date of deceased (mo., day, yr.) Jan 9 19028. AGE: Years 76 Months 7 Days 4 It less than one day hrs. . . . . min.9. Birthplace Mathias, Hardy Co. W. Va.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business General Farming12. Name Joshua Strawderman13. Birthplace Mathias W. Va.14. Maiden name Virginia Foltz15. Birthplace Mathias W. Va.16. Informant Calvin StrawdermanAddress 222 Fulton St - Cumberland Md17. Burial Date thereof Aug 16 1948  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory Please contact grave master, Cem.Location Near Cumberland Md.18. Funeral director John J. HaferAddress Cumberland19. Aug 16 1948 Walter R. Jones M. D. or other  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County WinchesterCity or town Winchester (If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 19 48 a.m. 8/13/48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 8/13/48 19 48 to 8/13/48 19 48

Immediate cause of death

Carcinoma of  
intestines tract

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations carcinoma)Date of op. 8/13/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

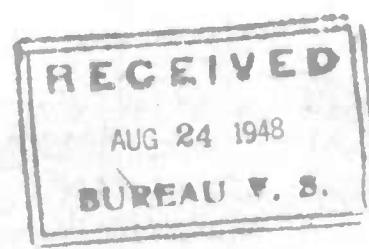
Means of injury

Injured at work?

23. SIGNATURE John K. Rossmann M. D. or otherAddress Cumberland Md. Date signed 8/16/48

to Roger  
and  
Rees

Call  
65



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07977

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Allegany  
City or town Midland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs.  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Thomas H. Tighe

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Wedowed6. (b) Name of husband or wife Margaret E. Stevenson7. Birth date of deceased (mo., day, yr.) Dec. 20, 1865

6. (c) If alive, give age

years

8. AGE:	Years <u>82</u>	Months <u>8</u>	Days <u>9</u>	If less than one day ..... hrs. ..... min.
---------	-----------------	-----------------	---------------	---

9. Birthplace Ireland  
(Town, county, and state)10. Usual occupation Coal Miner11. Industry or business Consolidation Coal Co.12. Name John Tighe13. Birthplace Ireland14. Maiden name Margaret Tighe15. Birthplace Garrett Co., Md.16. Informant Mrs. Walter RossAddress Midland, Md.17. Burial Date thereof Sept. 1, 1948  
(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director M. EichhornsAddress Loracorning, Md.19. Date record by registrar Sept. 1, 1948

(Date record by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County alleganyCity or town Midland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

DST

20. DATE OF DEATH 29 Aug 1948 at 10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Aug 1948 to 29 Aug 1948and that I last saw him alive on 28 Aug 1948Immediate cause of death CerebralHemorrhage & ParalysisDue to AtherosclerosisDue to Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results Non done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

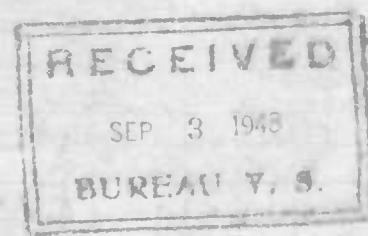
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John S. Davis, M.D.M. D. ✓Address Frostburg, Md. Date signed 8/30/48



## CERTIFICATE OF DEATH

Reg. Dist. No. ....

4

M

B

C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death of a newborn infant, give residence of mother.

## 1. PLACE OF DEATH:

County..... ALLEGANY .....

City or town..... CUMBERLAND .....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL .....

How long in hospital or institution? 2 DAYS

## 3. (a) FULL NAME

MISS LOIS JEAN TIPTON

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife.....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 20, 1928

8. AGE: Years Months Days It less than one day  
19 | 8 | 12 | hrs. min.

9. Birthplace..... WISCONSIN, Shawano

(Town, county, and state)

10. Usual occupation..... NONE

## 11. Industry or business

FATHER 12. Name..... EARL TIPTON

13. Birthplace..... WEST VIRGINIA

MOTHER 14. Maiden name..... WIEGT AND, GRACE

15. Birthplace..... WISCONSIN

16. Informant..... MEMORIAL HOSPITAL

Address..... MEMORIAL AVE., CITY

17. Burial Date thereof Aug. 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Davis Memorial Cem.

Location..... Oldtown Rd. Cumberland, Md.

18. Funeral director..... H. Wayne George

Address..... Cumberland, Md.

19. Aug. 5, 1948  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND

County..... ALLEGANY

City or town..... ROUTE #4

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No..... P.O. D. #4

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 2, 1948 at 11:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31, 1948 to Aug. 2, 1948

and that I last saw her alive on Aug. 2, 1948

Immediate cause of death..... Myocardial infarction

due to Diabetic Cerebra

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... 10 Bunting St. Date signed 8/6/48

RECEIVED  
AUG 10 1948  
BUREAU V. S.

**I** PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Dr. [unclear]**Within corporate limits*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

111C

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 4 days

## 3. (a) FULL NAME

DANIEL FRANKLIN  
Baby Boy Trimble

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

August 10, 1948

## 8. AGE:

Years  
0Months  
0Days  
4If less than one day  
hrs. min.

## 9. Birthplace

Cumberland, Allegany, Md.

(Town, county, and state)

## 10. Usual occupation

Infant

## 11. Industry or business

## MOTHER FATHER

Jesse Trimble

13. Birthplace Mt. Savage, Md.

14. Maiden name Suzanne Winebrenner

15. Birthplace Mt. Savage, Md.

## 16. Informant Jesse Trimble

Address Mt. Savage, Md.

## 17. Burial

Date thereof Aug 17, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory St. George Episcopal Cemetery

Location Mt. Savage, Md.

## 18. Funeral director

John J. Hoyer

Address Cumberland, Md.

19. Aug 17, 1948  
(Date read by registrar)Entered Q 3rd Inst  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH August 17, 1948, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

AUGUST - 10 1948, to AUGUST 14 1948

and that I last saw h. m. alive on AUGUST 14 1948

## Immediate cause of death

TETANY

DURATION

4 DAYS

Due to CALCIUM DEFICIENCY

Due to

## Other conditions

PULMONARY EDEMA

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

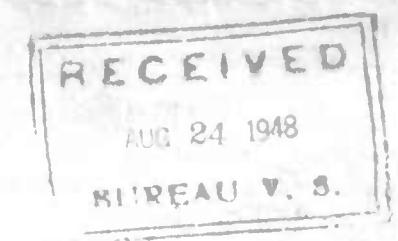
Injured at work?

## 23. SIGNATURE

William E. Mosley

M. D. other

Address Mt. Savage, Md. Date signed 8-16-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07980

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH: Allegany

County: Cumberland  
City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

906 Gay St.,

How long in hospital or institution?

## 3. (a) FULL NAME

WALTER JAMES VALENTINE

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

8. (b) Name of husband or wife: Sarah Twigg

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1890 | 6. (c) If alive, give age: 57 years

8. AGE: Years: 57 | Months: 9 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Bennett Transfer

12. Name: William Valentine

13. Birthplace: Md.

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Mrs. Sarah Valentine  
Address: 906 Gay St., Cumberland, Md.17. Burial: Date thereof: Aug. 14, 1948  
(Burial, cremation, or removal, Which?) Cemetery or crematory: Centenary Church Cem.

Location: Bedford Rd. near Cumberland

18. Funeral director: H. Wayne George  
Address: Cumberland, Md.19. Date registered by registrar: Aug. 14, 1948  
Registrar: Walter R. Long, M.D.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 906 Gay St.

(If rural, give LOCATION)

2. (a) If veteran, name war:

## 3. (b) Social Security Number

214-05-5843

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1948, 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1948, to Aug. 11, 1948,

and that I last saw him alive on August 1, 1948.

Immediate cause of death: congestive heart failure

Due to: chronic myocarditis

Due to: arteriosclerotic heart disease

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

## Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

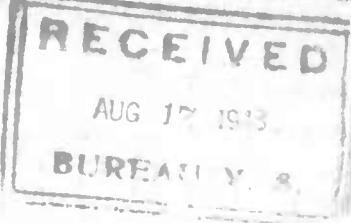
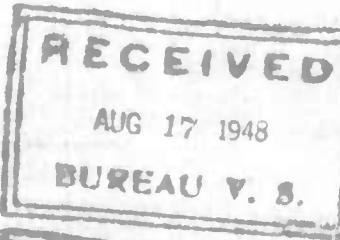
Injured at work?

23. SIGNATURE: (Wing III)

M.D. or other

Address: 38 Green St., Date signed: Aug. 14, 1948

Bieng



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07981

6

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Allegany

City or town..... Westernport.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 hour.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

James F. Walsh.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 1889.

8. AGE:

Years

Months

Days

If less than one day

58

11

6

hrs.

min.

9. Birthplace..... Piedmont, West Va.

(Town, county, and state)

10. Usual occupation.....

Bookkeeper- Clerk.

11. Industry or business.....

Campbell Coal Co.

MOTHER FATHER

12. Name..... Bryan Walsh.

13. Birthplace..... Ireland.

14. Maiden name..... Mary Ellen Bouhen.

15. Birthplace..... Bloomington, Maryland.

16. Informant.....

Joseph Walsh.

Address

Rowlesburg, West Va.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... August 10, 1948

(month) (day) (year)

Cemetery or crematory.....

St. Peters Cemetery.

Location.....

Westernport, Maryland.

18. Funeral director.....

Wm Harold Fidell Jr.

Address

Piedmont, West Va.

19. Date signed by registrar.....

August 14, 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... West Va. County..... Mineral.

City or town..... Piedmont. (If outside city or town limits, write RURAL and give nearest town)

Street No..... 90 West Hampshire. (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

232-01-1361

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 7, 1948. at 9 am. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1948, to Aug. 7th, 1948,

and that I last saw him alive on Aug. 7th, 1948.

Immediate cause of death..... Coronary Occlusion, DURATION

Due to.....

Due to.....

Other conditions..... Dilation of heart.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

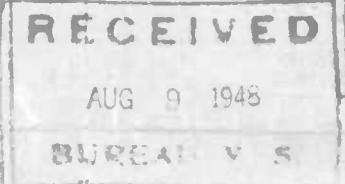
Means of Injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Piedmont, W. Va. Date signed..... August 14, 1948



**I** PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07982

93d

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County **ALLEGANY COUNTY**City or town **CUMBERLAND, MARYLAND**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

**MEMORIAL, CUMBERLAND, MD.**

17 HOURS

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **WEST VIRGINIA**, County **HAMPSHIRE**City or town **ROMNEY**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 3. (a) FULL NAME

**CHARLES E. WEBSTER**

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

COLORED

MARRIED

6. (b) Name of husband or wife

**BESSIE WASHINGTON WEBSTER**

7. Birth date of deceased (mo. day, yr.)

10/4 - 1870

6. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

77

9

29

hrs.

min.

9. Birthplace

**WEST VIRGINIA**

(Town, county, and state)

10. Usual occupation

**NONE**

11. Industry or business

MOTHER FATHER

**JOHN WEBSTER**

13. Birthplace

**W.VA.**

14. Maiden name

**HARRIET HARDY**

15. Birthplace

**WEST VIRGINIA**

16. Informant

**Memorial Hospital**

Address

**Cumberland, Md.**

17. Burial

Date thereof **August 6, 1948**  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

**Allegany County Cemetery**

Location

**Cumberland, Md.**

18. Funeral director

**John J. Hofer**

Address

**Cumberland, Md.**

19. Date rec'd by registrar

**Aug. 6 1948****W.L. Frank, M.D.**

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **WEST VIRGINIA**, County **HAMPSHIRE**City or town **ROMNEY**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

**None**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **AUG. 3, 1948** 19 **1948**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive **Aug. 3** 1948

Immediate cause of death

**Chronic myocarditis**

Due to

Due to

Other conditions **arteriosclerosis also****edema of arms & legs**

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

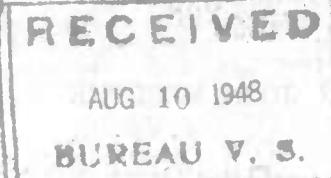
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

**Deputy Medical Examiner - Allegany Co.**23. SIGNATURE **H.V. Deming M.D. H.V. Deming M.D.** M. D. or otherAddress **Cumberland, Md.** Date signed **8-4-48**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07983

92d

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54-6-14

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland (If outside city or town limits, write RURAL and give nearest town)Street No. 19 S. Wardsy Street (If rural, give LOCATION)

2.(a) If veteran, name war

World War I

## 3.(a) FULL NAME

Charles A. Wegman

## 3.(b) Social Security Number

214-05-8936

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married6.(b) Name of husband or wife Mildred Pickens7. Birth date of deceased (mo. day. yr.) Feb 11 1894 6.(c) If alive, give age years8. AGE: Years 54 Months 6 Days 14 If less than one dayhrs. 0 min. 09. Birthplace Cumberland Ind. (Town, county, and state)10. Usual occupation Mechanic11. Industry or business Steel Co.12. Name Henry B. Wegman13. Birthplace Cumberland Ind. (Town, county, and state)14. Maiden name Helen Crowley15. Birthplace Penna16. Informant Mrs. Mildred J. WegmanAddress Cumberland17. Burial Burial Date thereof Aug 27 48 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S. Peter & Paul Cem.Location Cumberland Ind.18. Funeral director Louis Stein Inc.Address Cumberland19. Aug 26 1948 Entered by Walter P. Gray M.D. or other  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 Dec. 46 1946 to 25 Aug 48 1948and that I last saw him alive on 24 Aug 48 1948Immediate cause of death Valvular heart disease, mitral, rheumaticSince 1943Due to Subacute Bacterial EndocarditisDue to Other conditions 

(Include pregnancy within 3 months of death)

Major findings or operations Date of op. 

See above.

Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE W. Alfred V. Alexander M.D.

M. D. or other

Address 110 S. Centre St. Cumb. Date signed 26 Aug 1948

RECEIVED  
AUG 31 1948  
BUREAU V. S.

DR. W.F.WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07985

Me

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County GRANT

City or town MAYSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

MR. ASA WEIMER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWER

6.(b) Name of husband or wife

MARY ELIZABETH KEPLINGER

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

JUNE 8, 1876

8. AGE: Years

72

Months 2

Days 2

If less than one day hrs. min.

9. Birthplace

West VIRGINIA

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

MOTHER FATHER

WEIMER, ISREAL

13. Birthplace

WEST VIRGINIA

14. Maiden name

MARGARET F. BURGESS

15. Birthplace

PENNSYLVANIA

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/12/48

(month) (day) (year)

Cemetery or crematory Streetly Cemetery

near Peterburg, W. Va

Location P. E. Thrall &amp; Son

18. Funeral director

Address moorefield wva.

19. August 10 1948

(Date rec'd by registrar)

W.R. Tracy, M.D.

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

## MEDICAL CERTIFICATION

20. DATE OF DEATH

AUGUST 10,

1948

1:45A

I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 9, 1948, to August 10, 1948, and that I last saw him alive on August 10, 1948.

Immediate cause of death

Shock from intestinal obstruction (mechanical)

Due to

Duration 4 days

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Crippling edema Date of op. 8-9-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.F. Williams  
Cumberland 8/10/48  
Address M. D. - mother  
Date signed

RECEIVED  
AUG 17 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Johnson

Outside of  
City limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07990

47d

4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

County..... Allegany  
City or town R. D. #2 Williams Rd. Cumb. Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Williams Rd. Cumberland, Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Rural near Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Williams Rd. near Cumb.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1948, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 24, 1948, to Aug. 25, 1948,  
and that I last saw him alive on Aug. 24, 1948.

Immediate cause of death

Coronary Lung

DURATION

(3.)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. or other

B. M. Shandifer, M.D.  
Address 41 Leonard St. Date signed 13/1948

3. (a) FULL NAME  
DAVID WALKER WENTLING

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Nina May Long

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo. day. yr.) Jan. 1, 1873

8. AGE: Years 75 Months 7 Days 24 If less than one day hrs. min.

9. Birthplace Near Cumberland, Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

MOTHER FATHER John Wentling

13. Birthplace Penna.

14. Maiden name Emily McElfish

15. Birthplace Maryland

16. Informant Mrs. Nina Wentling

Address R. D. #2 Cumberland, Md.

17. Burial Date thereof Aug. 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Pleasant Cem.

Location Near Cumberland, Md.

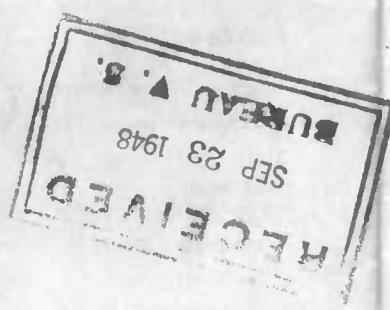
18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Aug. 28, 1948  
(Date rec'd by registrar)

Registrar

24/locne



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.  
 M  
 I  
 VS A15 9-45-15M  
 With city or town limits  
 Free William  
 is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

07984

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

519 Conrad Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

James H. White

## 4. Sex

M

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Mamie Thomas

6.(c) If alive, give age 66 years

## 7. Birth date of deceased (mo. day, yr.)

June 15, 1887

## 8. AGE: Years

61

Months

1

Days

If less than one day

18

hrs.

min.

## 9. Birthplace

Cumberland Allegany Co Md  
 (Town, county, and state)

## 10. Usual occupation

Paper Hanger

## 11. Industry or business

Self Employed.

## 12. Name

James H. White

## 13. Birthplace

Cumberland Md.

## 14. Maiden name

Caroline Elbin

## 15. Birthplace

Artemas, Pa.

## 16. Informant

Mrs. James H. White

## 17. Burial

519 Conrad Ave, Cumberland, Md.

Date thereof Aug 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Cumberland Md.

## 18. Funeral director

John J. Hafer

## Address

Cumberland Md.

## 19. Date rec'd by registrar

Aug 6, 1948 L.H. Branty M.D.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Allegany

City or town Cumberland

Street No. 519 Conrad Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

578-03-7137

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1948, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended/deceased from June 18, 1948, to July 19, 1948

and that I last saw h... alive on 19  
 Immediate cause of death  
 Cyanosis & Stomatitis  
 Regurgitation with mucus  
 to turn, mucus up  
 Due to  
 Small pulmonary  
 And was literally  
 filled with it.  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations  
 Ovarian varicose  
 Above was present of op. nose,

## Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

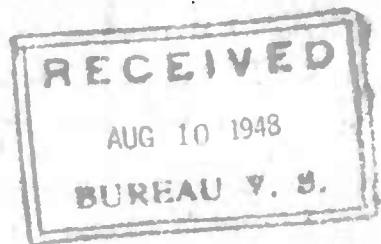
Injured at work?

## 23. SIGNATURE

A. H. Hawkins

M. D. or other

Address..... Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07986

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

57e

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

514 Frederick Street

How long in hospital or institution?

## 3. (a) FULL NAME

Catherine Wickertshain

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

FWWidow

## 6. (b) Name of husband or wife

Andrew Wickertshain

## 6. (c) If alive, give age .....

years

## 7. Birth date of deceased (mo., day, yr.)

May 6 1850

## 8. AGE:

Years	Months	Days	If less than one day
98	2	28	min.

## 9. Birthplace

Salzburg Austria(Town, county, and state)

## 10. Usual occupation

Housework

## 11. Industry or business

Home

MOTHER FATHER  
 12. Name George Sticker  
 13. Birthplace Austria

14. Maiden name Rosina Reiter  
 15. Birthplace Austria

16. Informant George Wickertshain  
 Address Cumberland MD

17. Burial Burial Date thereof Aug 7 '48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Sugar Grove Cemetery  
 Location Wilmington, Ohio

18. Funeral director LOUIS STEIN, INC.  
 Address Cumberland MD

19. Date rec'd by registrar Aug 5 1948 L.H. Tauny M.D.  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany  
 City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Street Frederick St.  
(If rural, give LOCATION)

## 2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Aug. 4 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1948 to Aug 19 1948  
 and that I last saw her alive on Aug 3 1948

Immediate cause of death

Intrastinal hemorrhageDue to Tumor of colon (Type undetermined)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

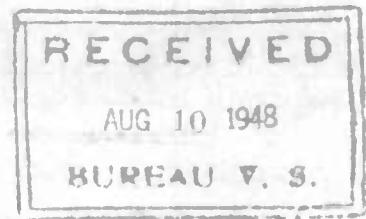
Means of injury Injured at work?

## 23. SIGNATURE

Arthur F. Jones M.D.

M. D. or other

Address 110 S. Centre St. Date signed 8-5-48



Within corporate limits  
Mr. Matthews  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07987

1316

4

Reg. Distr. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

5 days

## 3. (a) FULL NAME

James Wilson

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

## 6.(b) Name of husband or wife

Leatha Arnold

## 7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1883

8. (c) If alive, give age years

61

## 8. AGE:

Years

Months

Days

It less than one day

64

10

21

hrs.

min.

## 9. Birthplace

Barton Allegany Maryland

(Town, county, and state)

## 10. Usual occupation

Brewery worker

## 11. Industry or business

Cumberland Brewery

## MOTHER FATHER

12. Name Thomas Wilson

## 13. Birthplace

Scotland

## 14. Maiden name

Elizabeth ?

## 15. Birthplace

Scotland

## 16. Informant

Mrs. Leatha Wilson

## Address

527 Henderson Ave., Cumberland

## 17. Burial

Date thereof Aug. 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Rose Hill Cem.

Cemetery or crematory

Cumberland, Md.

## 18. Funeral director

H. Wayne George

## Address

Cumberland, Md.

## 19. Address

Aug. 7, 1948

(Date received by registrar)

Mr. Frank M. D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County Allegany

State Maryland

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 527 Henderson Ave. J.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

214-05-4845

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug. 5, 1948, at 8:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

030-4, 1944, to Aug. 5, 1948

and that I last saw him alive on Aug. 5, 1948

## Immediate cause of death

Chronic Myocarditis

Due to Charles Bronchitis

Due to Charles Bronchitis

Chronic Hepatitis

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Mr. Frank M. D.

M. D. or other

Address 49 Avenue St. Date signed 8/6/48



DR. TOPPER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07988

~~Within corporate limits~~

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**  
ALLEGANY  
County.....  
City or town..... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 6 DAYS  
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL  
How long in hospital or institution?..... 6 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)  
State PENNSYLVANIA County LANCASTER  
BAINBRIDGE  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(b) Social Security Number

3.(a) FULL NAME

NORMAN WITT

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE,

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 75 Months Days If less than one day hrs. min.

9. Birthplace PENNSYLVANIA  
(Town, county, and state)

10. Usual occupation FARMING, WORKED FOR OTHER

11. Industry or business FARMERS

12. Name WITT, JOHN  
13. Birthplace PENNSYLVANIA14. Maiden name SHOWORK, SUSAN  
15. Birthplace Hyndman, Pa.16. Informant MEMORIAL HOSPITAL  
CUMBERLAND, MD.17. Burial Date thereof aug. 30, 1948  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Palo Alto Cemetery

Location Hyndman, Pa.

18. Funeral director H. H. ZEIGLER,  
HYNDMAN, PA.

Address

19. Aug. 30, 1948 Hunter A. Tracy, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 27 48 at 2:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 21 1948 to Aug 27 1948

and that I last saw him alive on Aug 27 1948

Immediate cause of death Diphtheria, Melritis

Duration 4 days

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

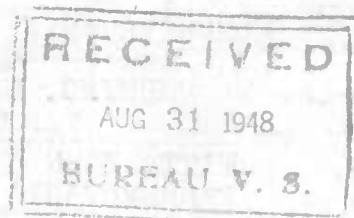
Means of injury Injured at work?

23. SIGNATURE John G. Topper M.D.

M. D. or other

Address Hyndman, Pa. Date signed 8/28/48

E6 81  
el  
BPHB



Within corporate limits  
DR SIMONS

Please write plainly, with unfading ink. Supply every item of information carefully. In case of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

07989

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

### 3. (a) FULL NAME

WILLIAM C. YEAGER

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6.(b) Name of husband or wife MARY CHRIST

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo. day, yr.) APRIL 20, 1900

8. AGE: Years Months Days If less than one day

48 3 10 hrs. min.

9. Birthplace CUMBERLAND, Alleg. Co., Md.

(Town, county and state)

10. Usual occupation CARPENTER

11. Industry or business Self

12. Name YEAGER, WILLIAM

13. Birthplace PRUSSIA

14. Maiden name MERTIE GROSS

15. Birthplace CUMBERLAND, Maryland

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE CITY

17. Burial Date thereof Aug. 13, 1948

(Burial, cremation, or removal. Which?)

Pleasant Grove

Cemetery or crematory

Location Rt. #40 near Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Date rec'd by registrar Aug. 12, 1948

W. P. Chaitz, M.D.  
Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 527 GREEN ST CITY

(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 10

19. 48, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 8 1948 to August 10 1948

and that I last saw him alive on August 10 1948

Immediate cause of death Heart

DURATION

Due to Cardiac vascular - end disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George M. Simons  
M. D. or other  
Memorial Hospital  
Address Date signed Aug. 10, 1948

